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ABSTRACT

This handbook is designed to provide registered occupational therapists and certified occupational therapy assistants with guidance in serving children with disabilities and their families under the auspices of the Individuals with Disabilities Education Act (IDEA). The first chapter provides an overview of provisions in the Individuals with Disabilities Education Act and other laws relating to occupational therapy services for children with disabilities. The next chapters provide guidelines for addressing five major elements of occupational therapy service delivery: (1) continuum of services (includes information on the elements of transition, effect of continuum within early intervention and school system settings, and transitions that ensure continuity); (2) clients of services (addresses interactions with clients, client roles and responsibilities, and reimbursement systems); (3) context of intervention (reviews aspects of performance contexts, models of service delivery in the environmental context, and person-activity-environment fit); (4) collaboration (discusses components of collaboration and the collaborative process in service delivery); and (5) outcomes (including student-specific outcomes, development and documentation of the individualized family service plan and individualized education program outcomes, and program-specific outcomes). Each of these chapters reviews relevant terms and legislative considerations. Sample forms, resources, and professional policies are included in the appendices. (Each chapter contains references.) (CR)

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Occupational Therapy Services for Children and Youth under the Individuals with Disabilities Education Act

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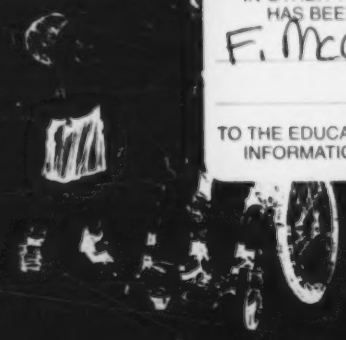

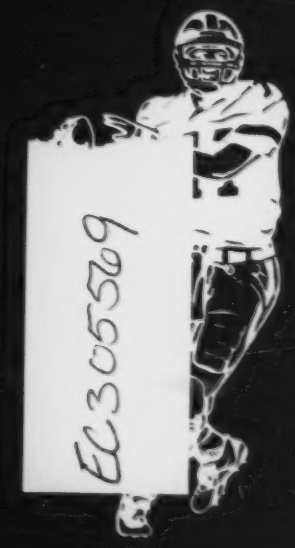

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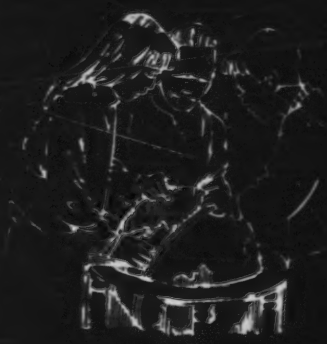

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OCCUPATIONAL THERAPY SERVICES FOR CHILDREN AND YOUTH UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

The American Occupational Therapy Association, Inc.

Bethesda, MD 20824-1220

by

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preface

This document has been developed to provide registered occupational therapists and certified occupational therapy assistants (OT practitioners) with guidance in serving children and their families under the auspices of the Individuals with Disabilities Education Act (IDEA). These guidelines replace two existing sets of guidelines published by the American Occupational Therapy Association: *Guidelines for Occupational Therapy Services in Early Intervention and Preschool Services* (Dunn, Campbell, Oetter, Hall, & Berger, 1989); and *Guidelines for Occupational Therapy Services in School Systems* (2nd edition) (Rourk, Andrews, Black, Dunn, Rabin, Stephens, & Wendt, 1989).

The Commission on Practice (COP), under the direction of Jim Hinojosa, PhD, OTR, FAOTA, conducted an extensive review of pediatric documents and solicited critiques from authors of previous guidelines, leaders in the profession, and practicing pediatric therapists. The review considered the degree to which information was current, useful in practice settings, and consistent with new legislative initiatives, along with the extent to which the documents represented *best practices* in educational settings. The COP concluded that the documents needed to be revised and convened a task force led by Elizabeth Maruyama, MPH, OTR/L. The School System/Early Intervention Guidelines Revision Task Force determined that the intent of IDEA is to provide a continuum of services across early intervention, preschool, elementary, and secondary education programs. To reflect that continuity, the task force developed one comprehensive set of guidelines.

ABBREVIATIONS AND ACRONYMS

ADA	=	Americans with Disabilities Act
ADL	=	Activities of Daily Living
AOTA	=	American Occupational Therapy Association
APE	=	Adapted Physical Education
CBM	=	Curriculum-Based Measurement
C.F.R.	=	Code of Federal Regulations
COP	=	Commission on Practice
COTA	=	Certified Occupational Therapy Assistant
CPT	=	Current Procedural Terminology
CSPD	=	Comprehensive System of Personnel Development
ECSE	=	Early Childhood Special Education
EI	=	Early Intervention
FAPE	=	Free Appropriate Public Education
ICC	=	Interagency Coordinating Council
IDEA	=	Individuals with Disabilities Education Act
IEP	=	Individualized Education Program
IFSP	=	Individualized Family Service Plan
LEA	=	Local Education Agency
LRE	=	Least-Restrictive Environment
NICU	=	Neonatal Intensive Care Unit
OT	=	Occupational Therapy or Occupational Therapist
OT Practitioner	=	Occupational Therapist (OTR) and Certified Occupational Therapy Assistant (COTA)
OTR	=	Occupational Therapist, Registered
PLEP	=	Present Level of Education Performance
PT	=	Physical Therapy or Physical Therapist
SEA	=	State Education Agency
U.S.C.	=	United States Code

Introduction to the Guidelines

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introduction to guidelines

The passage of Public Law 94–142 in 1975 greatly expanded public education opportunities for children with disabilities, making special education and related services such as occupational therapy (OT) more available. Since then, the number of OT practitioners working in the school system has increased rapidly. Before 1975, the school system was the fifth and sixth largest employment setting for registered occupational therapists (OTRs) and certified occupational therapy assistants (COTAs), respectively. By 1982, the school system ranked second and third, and in 1995 was the primary employment setting for OTRs and the second-ranked setting for COTAs (AOTA Research Department, Communication with Gerda Gaidelis, June 4, 1996).

These guidelines are based on federal law. Readers are referred to their state and local laws and regulations for further details about how the law is implemented in their states.

PURPOSE OF THE GUIDELINES

These guidelines were developed to provide OT practitioners, parents, educators, program administrators, and reimbursers with the following:

- an overview of the conceptual framework for *best practices* for occupational therapy services under the Individuals with Disabilities Education Act (IDEA)
- a description of the primary components of IDEA and related legislation
- analyses of the implications of IDEA for OT service delivery.

In designing these guidelines, the task force, with input from the Commission on Practice (COP) and members of the American Occupational Therapy Association (AOTA), identified current best practices and developed an organizational framework and strategies to enhance their use. *Best practice* refers to approaches that go beyond those typically available. Best practices most often result from research activities, model programs, or other types of experimental or innovative approaches. These approaches may not be used with all children and families, but may be available, for example, to children enrolled in particular experimental programs, to families enrolled in specific research studies, or to children with specific diagnoses or developmental patterns.

GUIDING ASSUMPTIONS

The following assumptions form the conceptual foundation for these guidelines:

1. Occupational therapists and certified occupational therapy assistants provide essential services to infants, toddlers, children, and youth with disabilities and their families. These professionals bring special perspectives to early childhood and educational teams, particularly in situations where a child's development and occupational performance are disrupted by disabilities or vulnerabilities in activities of daily living, in work and productive activities, and in play or leisure (AOTA, 1994). OT practitioners provide individualized, contextualized, culturally relevant services by building effective partnerships with children, family members, educators, and other

providers from a broad range of educational, medical, and social service disciplines.

2. IDEA provides the structure for occupational therapy services in early intervention and educational settings. Occupational therapy practitioners are members of a team whose mission is the following:

- to address the needs, priorities, and concerns of the child and family
- to support the learning and social experiences of children
- to promote academic achievement
- to enhance student role behaviors
- to maximize the person-environment fit
- to facilitate the involvement of family members
- to prepare students to leave school and participate in their community
- to contribute to the understanding and efforts of all team members.

3. The central tenets of IDEA are consistent with the philosophy of occupational therapy and provide additional opportunities for OT practitioners to make substantive contributions in the lives of children with special needs and their families.

4. Best practice incorporates the following approaches to form effective partnerships with children and families (e.g., Hanft, 1989; Lawlor & Cada, 1993; Leff & Walizer, 1992; Schaaf & Mulrooney, 1989) to recognize, respect, and integrate the views of all team members (e.g., Edelman, Greenland, & Mills, 1993; McGonigel, Kaufmann, & Johnson, 1991); to share the responsibility for service implementation; and to use knowledge and apply skills cost-effectively to promote development (Shonkoff, Hauser-Cram, Krauss, & Upshur, 1992) and improve occupational performance.

5. OTRs and COTAs who practice in educational and early childhood settings must coordinate their services with other providers, promote interagency collaboration, and assist families in negotiating the multiple systems that deliver service and that are often involved with children and families. Although these guidelines specifically address IDEA, the task force recognizes that practitioners must simultaneously comply with related legislation, including Maternal and Child Health initiatives, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act (ADA). Where possible, these related initiatives and their implications are incorporated into the guidelines. However, individual practitioners are responsible for using these guidelines in a manner consistent with all other state and local laws and workplace policies, and must keep abreast of changes resulting from new federal, state, and local legislation.

ORGANIZATION OF THE GUIDELINES

These guidelines identify five basic elements of OT practice as it is governed by IDEA and in accordance with existing

AOTA documents, professional consensus, and a review of relevant literature. Subsequent sections of these guidelines discuss the implications for OT practice.

A Continuum of Services

One of the best practices under IDEA involves providing a continuum of multifaceted services, a concept that is central to OT philosophy. Services should be adjusted as the developmental and life cycle needs of the child and family change. Thus, the continuum of care ensures that children and families will be supported during periods of transition and will have access to multiple services delivery and program options. As part of that continuum, the therapist must recognize the dynamic nature of service needs, provide flexibility, and promote access to services that respond to changing needs.

Clients of Services

While OT practitioners are most familiar with the individual child or family being the direct client of services, other individuals, groups, agencies, or systems may also receive OT services. The type of OT service delivery often depends on who is the recipient of service or who is the actual client. Throughout the continuum of service delivery, either the client may change or the focus of service delivery may shift. The process of service delivery must be interactive if the developing and changing needs of the client are to be addressed. In most situations, OT practitioners will have multiple clients. The use of the terms "recipient" and "client" is not intended to imply a hierarchy or to diminish the importance of collaborative, collegial, or partnership models of service delivery.

Factors to consider that define the client are eligibility criteria, roles and responsibilities, service delivery options, and reimbursement policies. The trend of providing delivery models that are family centered as well as client centered is incorporated in client mix.

Context

For an OT practitioner, the child, the context, and occupational performance are intertwined. To effectively assess and plan interventions, the OT practitioner must consider the child's interaction within the context (environment and temporal aspects) in which treatment takes place. The OT practitioner also must consider the value that the family (including the child) and the community (including the school) place on the child's context and the environment's influence on the child's performance. The multiple dimensions of the context include

- the person-environment fit
- the demands of the environment
- multiple cultures (i.e., family, school, OT profession, and individual concepts of culture held by the therapists and the child)
- temporal aspects of the environment
- physical and social dimensions
- safety issues.

Understanding the context of services also involves

- promoting the least-restrictive environments for performance

- supporting inclusion
- identifying characteristics of educational, medical, and community-based models of services.

Collaboration and Partnerships

OT services use interdisciplinary team structures that consist of children, their family members, and other service providers. These teams, or partnerships, are central components to services provided under IDEA. OT practitioners often work on multiple teams for several clients in both formal and informal networks. Interdependence is key to the design and implementation of services. Successful implementation depends on good communication, cooperation, negotiation, mutual interests, service coordination and integration, effective teamwork, and leadership. Other collaborative activities that can enhance the provision of occupational therapy services include mentoring, supervision, and the use of nonoccupational therapy personnel.

Outcomes

Occupational therapists and certified occupational therapy assistants are concerned with both the process and the product of their services, but all OT services must be directed toward and concerned with the effects or outcomes of those services. Outcomes related to services provided through IDEA are differentiated according to age (i.e., infant and toddler, preschool, elementary, and secondary age).

Outcomes or results of occupational therapy services should be linked to curriculum-related goals, success in child or student roles, and educational performance. Traditionally, outcome assessment has focused on discrete changes in the child's performance level. With the broadening of AOTA's definition of client comes expanded responsibilities in evaluating these outcomes. The shift toward more collaborative service delivery models has resulted in increased sharing of responsibility for student-specific outcomes. Measuring program-specific outcomes is also important to determine the overall effectiveness of the OT services and of the viability of such services in early intervention and school system settings.

Types of outcome measures include program accountability, productivity, program evaluation, satisfaction, and assessment of service delivery (e.g., frequency, duration, and documentation). Outcome assessment must also include knowledge of the context along with the influence of that context on performance.

USE OF THE GUIDELINES

Although the five major elements of OT service delivery under IDEA are described in separate chapters, it is the task force's intent to have readers reflect on the interrelatedness of those elements. When appropriate, case examples and vignettes have been provided to demonstrate the integration of these components in actual practice. Each section includes a checklist of questions to assist the reader in relating the concepts to their individual practice. Additional resources and references are listed at the end of each chapter. The Appendix includes several official AOTA documents that pertain to the topics covered in these guidelines. A list of

abbreviations and acronyms common to both early intervention and school system practice is on page iv.

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Legislation

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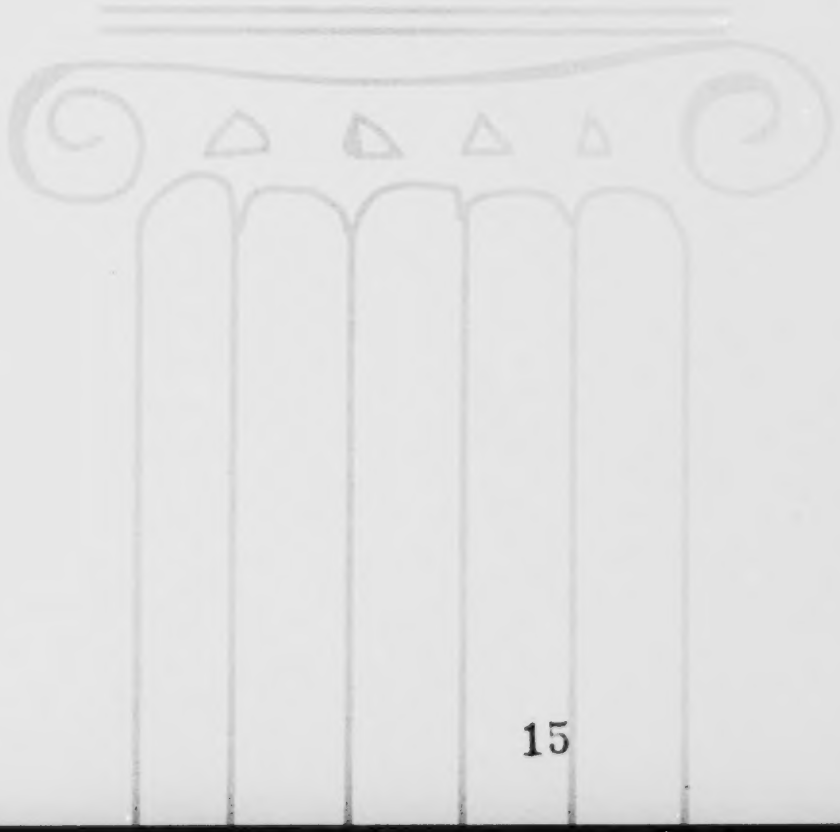

This chapter provides information on federal laws that authorize services for children with disabilities and their families. Although the predominant focus is on the Individuals with Disabilities Education Act (IDEA), it is important for OT practitioners to understand the legal and legislative foundation for their services in early intervention, preschool, and school settings. The reader is also referred to the state special education and early intervention laws and rules and regulations that specifically describe how services will be provided in a given state.

Note: IDEA is undergoing reauthorization while these guidelines were being developed. Thus, the discussion in the guidelines is based on current law and regulation, which is subject to change.

DEFINITION OF TERMS

Law (also known as code) is an act of Congress that has been signed by the president, or passed by Congress over the president's veto. The code is divided into subparts, and each subpart may have one or more sections.

Federal regulations are rules generated by administrative agencies to help implement laws. These rules translate and interpret the broad and unspecific policies and procedures outlined in the law. The U.S. Department of Education generates regulations for IDEA.

State laws about early intervention and special education, along with state rules and regulations, are derived from the federal law and from federal rules and regulations. States may expand services, but may not restrict them.

Occupational therapy is defined in the Code of Federal Regulations (C.F.R.) as a related service in IDEA, Part B, and as an early intervention service in IDEA, Part H.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

Brief History

The Individuals with Disabilities Education Act (IDEA) was originally enacted by Congress in 1975 as the Education of the Handicapped Act (EHA), Public Law 94–142. EHA, which consolidated a number of separate federal grant programs for children with disabilities under one law, was the first freestanding statute written specifically for U.S. children who have disabilities and who are ages 5–21 (U.S. Department of Education, 1995).

The 1986 Amendments to the EHA (Pub. L. No. 99–457) added an early childhood component to the law. In addition to mandating services for preschool-age children with disabilities (Part B, §619), the amendments also gave states the option of developing statewide systems for providing services to infants and toddlers and their families (Part H).

The 1990 EHA amendments changed the name to the Individuals with Disabilities Education Act (Pub. L. No. 101–476). By 1991, additional vital services relevant to occupational therapy were added: assistive technology devices and services and transition planning (Pub. L. No. 102–119). IDEA also increased the focus, funds, programs, and services for

students with emotional disturbance. Changes in Part H, which covers early intervention, included substitution of the terms *service coordinator* for *case manager,* and *adaptive behavior* for *self-care* in the definition section.

The Individuals with Disabilities Education Act (IDEA) contains eight parts:

Part A—General Provisions

- Definitions
- Office of Special Education Programs
- Acquisition of Equipment and Construction of Necessary Facilities
- Employment of Individuals with Disabilities
- Grants for the Removal of Architectural Barriers
- Regulation Requirements
- Eligibility for Financial Assistance

Part B—Assistance for Education of All Children with Disabilities

- Entitlements and Allocations
- Eligibility Requirements
- State Plans
- Applications
- Procedural Safeguards
- Withholding and Judicial Review
- Administration
- Evaluation and Program Information
- Preschool Grants
- Payments

Part C—Centers and Services to Meet Special Needs of Individuals with Disabilities

- Regional Resource and Federal Centers
- Services for Deaf-Blind Children and Youth
- Early Education for Children with Disabilities
- Programs for Children with Severe Disabilities
- Postsecondary Education
- Secondary Education and Transitional Services for Youth with Disabilities
- Programs for Children and Youth with Serious Emotional Disturbance
- Authorization of Appropriations

Part D—Training Personnel for the Education of Individuals with Disabilities

- Grants for Personnel Training
- Grants to State Educational Agencies and Institutions for Traineeships
- Clearinghouses
- Reports to the Secretary
- Authorization of Appropriations

Part E—Research in the Education of Individuals with Disabilities

- Research and Demonstration Projects in Education of Children with Disabilities
- Research and Demonstration Projects in Physical Education and Recreation for Children with Disabilities
- Authorization of Appropriations

Part F—Instructional Media for Individuals with Disabilities

- Purpose
- Captioned Films, Television, Video, and Educational Media for Persons with Disabilities
- Authorization of Appropriations

Part G—Technology, Educational Media, and Materials for Individuals with Disabilities

- Financial Assistance
- Authorization of Appropriations

Part H—Infants and Toddlers with Disabilities

- Findings and Policy
- Definitions
- General Authority
- General Eligibility
- Continuing Eligibility
- Requirements for Statewide System
- Individualized Family Service Plan
- State Application and Assurances
- Uses of Funds
- Procedural Safeguards
- Payor of Last Resort
- State Interagency Coordinating Council
- Federal Administration
- Allocation of Funds
- Federal Interagency Coordination Council
- Authorization of Appropriations

Note: To obtain a copy of the *Code of Federal Regulations*, write to Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402. Request *34 Code of Federal Regulations—Parts 300 to 399* (the most recent revision). The *Code of Federal Regulations* is revised annually. The 34 denotes regulations dealing with education.

Main Premise of IDEA

IDEA requires states to provide each eligible child or youth (ages 3–21) with a disability a "free, appropriate public education" (FAPE). To assist states in providing FAPE, IDEA currently authorizes three state formula grant programs (Parts B, H, and §619 of Part B) and several programs for discretionary grants (personnel preparation; research, demonstration, and dissemination projects; information clearinghouses; and parent-training centers). The three state formula grant programs are briefly discussed in the following section.

Part B—Assistance to States for the Education of Children with Disabilities (34 C.F.R., Part 300). The purpose of Part B of IDEA is to "ensure that all children with disabilities have available to them a free appropriate public education that includes special education and related services to meet their unique needs; ensure that the rights of children with disabilities and their parents are protected" (34 C.F.R. §300.1(a)(b)). This also applies to other agencies of the state that are involved in the education of children with disabilities, and children and youth referred to or placed in private schools and facilities by that agency (34 C.F.R. §300.2(b)(c)).

Section 619 of Part B—Preschool Grants for Children with Disabilities (34 C.F.R., Part 301). The Preschool Grants program provides assistance to states to provide "special education and related services to children with disabilities aged three through five, and, at a State's discretion, providing a free appropriate public education to two-year-old children with disabilities who will reach age three during the school year; plan and develop a statewide comprehensive delivery system for children with disabilities from birth through age five years; and provide direct and support services to children with disabilities aged three though five years" (34 C.F.R. §301.1).

Part H—Early Intervention Program for Infants and Toddlers with Disabilities (34 C.F.R., Part 303). Part H provides financial assistance to states to "develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families; facilitate the coordination of payment for early intervention services from Federal, State, local and private sources..." (34 C.F.R. §303.1(a)(b)).

Table 2.1 compares selected provisions of Part B and Part H. Note that segments of this table will be repeated in other chapters as those segments pertain to chapter content.

Occupational Therapy Under IDEA

OT services are provided differently under Part B and Part H. Similarities and differences are briefly discussed next.

Part H. Occupational therapy is considered a *primary service* under the IDEA early intervention program for children birth through age 2. As a primary service, OT can be provided separately or along with any other early intervention services the child and family might need. Early intervention services are designed around an individualized family service plan (IFSP) to meet the "developmental needs of each child ... and the needs of the family related to enhancing the child's development" (34 C.F.R. §303.12). The IFSP, which is adopted by the family and a multidisciplinary team, includes the expected outcomes for the child and family that should guide intervention.

To receive occupational therapy services under Part H, the infant or toddler must meet eligibility criteria as established by the state of residency.

Part B. IDEA provides for a free appropriate public education (FAPE) in the least restrictive environment (LRE) for children with disabilities ages 3 through 21 "who, by reason thereof, need special education and related services." *Related services* are "such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes ... occupational therapy" (34 C.F.R. §300.16). *Special education* means "specially designed instruction" that meets the unique needs of the child with a disability. In addition to instruction in the classroom, special education includes instruction at home, in a hospital, and in other institutions; physical education; speech pathology (if considered special education instruction); and vocational education.

TABLE 2.1—SELECTED COMPARISONS OF IDEA: PART B AND PART H

(Note: Adapted from the Individuals with Disabilities Education Act, 20 U.S.C., Chapter 33)

Issue	Part H	Part B
Occupational Therapy	A primary service for eligible infants and toddlers from birth through age 2 who qualify for early intervention services that "are designed to meet the developmental needs of the child ... and the needs of the family related to enhancing the child's development" (§303.12 (1)). "Includes services to address the functional needs of the child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include identification, assessment, and intervention · adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills · prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability" (§ 303.12 (8)(i)(ii)(iii)).	A related service for eligible students ages 3 through 21 who require "... such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education" (§300.16(a)). "Includes · improving, developing or restoring functions impaired or lost through illness, injury, or deprivation · improving ability to perform tasks for independent functioning when functions are impaired or lost · preventing, through early intervention, initial or further impairment or loss of function" (§300.16 (5)(i)(ii)(iii)).

TABLE 2.1 (continued)

Issue	Part H	Part B
Eligibility	Infants and toddlers birth through age 2 who are experiencing developmental delays in one or more of the following areas: • cognitive development • physical development • communication development • social or emotional development • adaptive development or Have a diagnosed physical or medical condition that has a high probability of resulting in developmental delay. May include, at a state's discretion, children from birth through age 2 who are at risk of having substantial developmental delays if early intervention services are not provided.	Children with disabilities evaluated ... as having • mental retardation • hearing impairments, including deafness • speech or language impairments • visual impairments • serious emotional disturbance • orthopedic impairments • autism • traumatic brain injury • other health impairments • specific learning disabilities • deaf-blindness/multiple disabilities and who because of these impairments need special education and related services. May include at a state's discretion, children ages 3 through 5 who are experiencing developmental delays, as defined by the state.
Required Services	Early intervention services are designed to • meet the developmental needs of the child and family related to the child's development • meet state standards and are provided under public supervision by qualified personnel. Services include • family training, counseling, and home visits • special instruction • speech pathology • audiology	Free appropriate public education (FAPE) are services meeting state standards and are provided under public supervision by qualified personnel. Services include • special education (specially designed instruction) to meet the unique educational needs of the child including classroom instruction, instruction in physical education, home instruction, instruction in hospitals and institutions, vocational education (if specially designed)

Issue	Part H	Part B
Required Services (con't)	• occupational therapy • physical therapy • psychological services • service coordination • medical services only for diagnostic or evaluation purposes • early identification, screening, and assessment services • health services • social work services • vision services • nursing • nutrition services • assistive technology devices and services • transportation and related costs necessary to receive early intervention services.	• related services needed by the child to benefit from special education • transportation, developmental, corrective, and other supportive services including – speech pathology and audiology – psychological services – physical and occupational therapy – recreation – social work services – counseling services – medical services (diagnostic and evaluation only) – parent training and counseling – assistive technology devices and services – rehabilitation counseling – school health services.
Team Models	Multidisciplinary with family-centered focus specific to the developmental needs of the child.	Multidisciplinary with student-centered focus specific to the student's educational/learning needs.
Environment (Locations of Service Delivery)	To the maximum extent appropriate, services are to be provided in natural environments, including home and community settings, in which children without disabilities participate.	To the maximum extent appropriate, children with disabilities are to be educated with children who are not disabled, and that ... removal of these children from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily (Least restrictive environment [LRE]).

TABLE 2.1 (continued)

Issue	Part H	Part B
Individualized Plan Requirements	Individualized Family Service Plan (IFSP) IFSP components emphasize a family-centered approach addressing the developmental needs of children and families. Service coordinator facilitates written plan for providing early intervention to child and family as soon as possible after the IFSP meeting. With parent consent, services may begin before evaluation and assessment are complete via an interim IFSP. Must include • statement of present levels of physical, cognitive, communication, social or emotional, and adaptive development based on acceptable objective criteria • family information, with their agreement, on resources, priorities, and concerns related to the child's development • statement of major outcomes expected for the child and family with criteria, procedures, and time lines used to determine progress and changes needed • statement of specific early intervention services necessary, including frequency, intensity, and method of delivering services • statement of natural environments in which early intervention services shall appropriately be provided	Individualized Education Program (IEP) IEP components emphasize meeting the student's educational needs through services, which the school must ensure are available. Written plan must be in effect at the beginning of each school year and before any special education and related services are provided. It should be implemented as soon as possible after the IEP meeting. Must include • statement of the present level of educational performance. • annual goals, including short-term instructional objectives. • specific special education and related services to be provided, and the extent that the child will be able to participate in regular education programs. • statement of the needed transition services for students beginning no later than age 16 and annually thereafter (can begin at age 14 or younger when appropriate). Plan also includes, when appropriate, a statement of interagency responsibilities of linkages before student leaves school setting. • projected date for initiation and anticipated duration of services. • appropriate objective criteria and evaluation procedures and schedules for determining, on at least an

TABLE 2.1 (continued)

Issue	Part H	Part B
Individualized Plan Requirements (con't)	• dates for initiation of services and the anticipated duration of each service • name of the service coordinator responsible for IFSP implementation and coordination • transition plan for the toddler's exit from Part H into Part B or other services, as appropriate.	annual basis, whether instructional objectives are being achieved.
Required IEP/IFSP Meeting Participants	Parents or guardians, family members, service coordinator, and other specialists, as needed.	Student's teacher, representative of the local education agency (LEA) who can provide and supervise the provision of special education, parents or guardian, other individuals at parent's or agency's discretion, and the child (if appropriate).
Transition Services	"Procedures to smoothly move the child from early intervention to Part B services, if appropriate, including how families will be included" (§303.148). A conference must be convened at least 90 days before the child's third birthday or, if earlier, the date on which the child is eligible for the Part B preschool program. A written plan must be established and is included in the IFSP.	"A coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities (including post-secondary education, vocational training, integrated employment, continuing and adult education, adult services, independent living, or community participation)" (§300.18). Services must be based on the student's needs and include instruction, community experiences, the development of employment and other postschool adult-living objectives, and if appropriate, acquisition of daily living skills and functional vocational evaluation. Written plan must be included in the IEP beginning no later than age 16.

TABLE 2.1 (Continued)

Issue	Part H	Part B
Timelines for Review of Individualized Plans	Every 6 months or more frequently if conditions warrant, or if the family requests such a review.	Meetings must be held at least once a year to review each child's IEP and, if appropriate, revise its provisions.
Funding	Each state designates a lead agency that is responsible for identifying and coordinating all available resources for early intervention in the state including various federal, state, local and private sources. The lead agency must enter into formal interagency agreements in this regard. States may set sliding scale fees for early intervention services except child find, evaluation and assessment, service coordination, administrative and coordination activities related to the IFSP and procedural safeguards.	All services must be provided at no cost to the parents. The state may use whatever federal, state, local, and private sources are available to do so. Part B does not relieve an insurer or other third party from an otherwise valid obligation to provide or pay for services.
Parental Rights	Written prior notice must be given whenever state agency or service provider proposes to initiate or change, or refuses to initiate or change identification, evaluation, placement, or provision of appropriate early intervention services. Notice must fully inform in the native language. Parental consent is required for initial evaluation and release of information. Parent(s) has right to accept or decline any early intervention service.	Written prior notice must be given whenever proposing to initiate or change, or refusing to initiate or change, the identification, evaluation, or educational placement. Notice must fully inform in the native language. Parental consent is required for initial evaluation and placement in special education and related services. Consent may be withdrawn at any time. Consent for release of information is required.

TABLE 2.1 (continued)

Issue	Part H	Part B
Parental Rights (con't)	Parental rights provisions also include • right to confidentiality per the Family Educational Rights and Privacy Act (FERPA), and confidentiality requirements established in IDEA, Part B • right to inspect and review child's records. Parent(s) can request amendments to the record; a hearing process is prescribed if the agency/local service provider disagree • timely administrative resolution of individual child complaints by the parent • protection of child's rights when parents/guardian are unknown or the child is ward of state. During pendency of any proceeding or action involving a complaint, child must continue to receive services currently being provided unless parent and agency otherwise agree.	Parent(s) has the right to inspect and review child's records (FERPA and confidentiality requirements established in Part B apply). Parent(s) can request amendments to the record; a hearing process is prescribed if agency/local service provider disagrees. Procedures are in place to protect the rights of the child whenever parent/guardian is unknown or child is ward of the state. Parent or agency may initiate an impartial due process hearing on any matter related to when an agency proposes or refuses to initiate or change the identification, evaluation, or educational placement of child, or provision of FAPE. During pendency of any judicial or administrative proceeding regarding a complaint, child must remain in present educational placement unless parent and agency otherwise agree. This "stay-put" provision is modified by the Gun-Free Schools Act of 1994 if the student brings a firearm to school and the behavior is not related to their disability.
Continuum of Alternative Placements	To the maximum extent possible for the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate.	Each public agency shall ensure that a continuum of alternative placements is available to meet the needs of children with disabilities for special education and related services.

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TABLE 2.1 (continued)

Issue	Part H	Part B
Continuum of Alternative Placements (con't)		IEP plan must include alternative placements listed in the definition of special education (see Required Services above), and make provision for supplementary services to be provided in conjunction with regular class placement.
Evaluation Requirements	Must include timely, comprehensive, multidisciplinary evaluation for each child referred for evaluation, including assessment activities related to the child and family. Must be conducted by personnel trained in appropriate methods and procedures, be based on informed clinical opinion, and include • review of pertinent records related to the child's current health status and medical history • evaluation of the child's level of functioning in each of the five developmental areas (see Eligibility above) • assessment of the unique needs of the child in terms of each of the developmental areas, including identification of services appropriate to meet those needs. A family-directed assessment (with any assessment voluntary on part of the family) to determine family resources, priorities and concerns	Tests and other evaluation materials are provided and administered in the child's native language or mode of communication and are nondiscriminatory. Materials and procedures are administered by trained personnel in conformance with the instructions provided by their producer, are validated for the specific purpose for which they are used, assess the specific areas of educational need. No one procedure shall be the sole criterion for determining an appropriate educational program. Made by a multidisciplinary team, including at least one teacher or specialist with knowledge about the suspected disability. The child is assessed in all areas related to the suspected disability. Placement is based on information from a variety of sources, documenting and considering all data sources. Decisions are made by a group of persons, including persons knowledgeable about the child, the

TABLE 2.1 (continued)

Issue	Part H	Part B
Evaluation Requirements (con't)	related to enhancing the child's development. It must be based on information provided by the family through personal interview and incorporate family's description of resources, priorities, and concerns related to enhancing the child's development. IFSP shall be developed within a reasonable amount of time after the assessment is completed. Early intervention services may begin prior to the completion of the evaluation and assessment, if parents consent and an interim IFSP is developed.	meaning of the evaluation data, and the placement options. An IEP must be developed if the child needs special education and related services. Reevaluation is conducted every 3 years, or more frequently if conditions warrant, or if the child's parent or teacher requests it. Parents have the right to get an independent educational evaluation, which must be considered by the agency related to FAPE or by a hearing, which may be at public expense if requested by a hearing officer or if the parent disagrees with agency evaluation (which the agency can contest through a hearing).
Assistive Technology Devices and Services	*Assistive technology device* is defined as "any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities" (§303.12(d)(1)). *Assistive technology service* is "any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device" (§303.12(d)(1)(i)–(vi)).	The same as Part H (§300.5, §300.6).

TABLE 2.1 (continued)

Issue	Part H	Part B
Assistive Technology Services and Devices (con't)	Services include • evaluation of the needs, including a functional evaluation in the customary environment • purchasing, leasing, or otherwise providing for the acquisition of assistive technology devises • selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices • coordinating and using other services with assistive devices • training or technical assistance for student or, when appropriate, family • training or technical assistance for professionals.	

Special education and related services are part of a child's individualized education program (IEP), which specifies the educational program that is tailored to meet the child's specific needs. According to case law and contrary to popular belief, the IEP does not mean the *best* or maximum education possible (Osborne, 1995; Hanft, 1995), but should confer educational benefit "likely to produce progress, not trivial educational advancement" (Osborne, 1995, p. 3).

For a student to receive OT services under Part B, the federal law requires that the student be eligible for special education *and* that the related service (occupational therapy) be necessary to assist the child with a disability to benefit from special education. In this manner, OT serves in a *supportive role* in helping the student to participate in and benefit from special education.

OTHER FEDERAL LAWS THAT AFFECT OT IN EARLY INTERVENTION AND SCHOOL SETTINGS

In addition to IDEA, other federal laws affect occupational therapy practitioners. This section and Table 2.2 elaborate on these laws.

Section 504 of The Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA)

Sometimes a student with a disability is not eligible for special education services yet has difficulty participating in and benefiting from educational programs. Under Section 504 of Title V of the Rehabilitation Act of 1973 (Pub. L. No. 93–112) and Title II of the Americans with Disabilities Act (ADA), (Pub. L. No. 101–336), such students might be eligible for occupational therapy services as a reasonable accommodation to help them learn. Both the ADA and its Section 504 predecessor provide protections against discriminatory practices on the basis of disability in all federally assisted programs and activities. OT intervention under Section 504 and the ADA focuses on facilitating the child's educational performance in a manner similar to IDEA.

Under Section 504, any student who is currently disabled cannot be denied or excluded from services if they are needed in order to benefit from a free and appropriate public education (29 U.S.C., Section 794). The definition of disability in Section 504 and the ADA is much broader than the disability categories specified in the IDEA. Section 504 identifies individuals as disabled if they have a physical or mental impairment which substantially limits a major life activity, has a record of the impairment, or is regarded as having such an impairment (29 U.S.C., Section 706[8]). The ADA utilizes a similar definition of disability (28 C.F.R., Part 36). Thus, eligibility for services and/or accommodations is dependent on having a condition which "substantially limits one or more ...major life activities" (Copenhaver, 1995; Roberts & Mather, 1995), which includes learning. The student is not eligible for services under Section 504 if this criteria is not met.

The quality of educational services to students with disabilities provided under 504/ADA must be equivalent to the services provided to nondisabled students (Roberts & Mather, 1995). While school districts are not required to develop an IEP for students served under Section 504 or the ADA, it is recommended that they document services and/or accommodations being provided. If extensive accommodations are necessary, a team should meet to develop a plan that outlines the needed services and accommodations (MPRRC, 1995).

In the 1986 amendments to the Rehabilitation Act of 1973 (Pub. L. No. 99–506), Section 504 required schools that receive federal funds to provide a modified school lunch at no extra charge to students who are disabled. The U.S. Department of Agriculture's Food and Nutrition Service, which oversees these school programs, issued instructions on October 14, 1994, expanding and clarifying the school's role in meal substitution for students with special needs. Occupational therapists and certified occupational therapy assistants provide services to students who may benefit from changes in food or liquid textures, menu modification, special utensils, and cafeteria accommodations. These changes must be provided through the school district at no extra cost if the school receives federal funds.

TABLE 2.2—SUMMARY OF FEDERAL LAWS AND ROLE OF OT

Law	General Purpose	Role of OT
Section 504 of the Rehabilitation Act of 1973	A broad civil rights law that protects the rights of individuals with disabilities in programs and activities that receive federal financial assistance from the U.S. Department of Education. Section 504 requires a written educational accommodation plan for any student who meets the definition of disabled. There is no additional funding for this mandate.	This law is the responsibility of general education. OT role may vary: provide assistance in environmental adaptations, acquire or modify equipment or devices, assist in developing the written educational accommodation plan. Any school that receives federal funds for their breakfast and lunch program must modify or make substitutions in meals for students whose disabilities restrict their diet, such as providing blended foods, special diets, utensils, etc., at no extra cost.
Americans with Disabilities Act of 1990 (ADA)	A civil rights law that provides a clear and comprehensive national mandate to eliminate discrimination against individuals with disabilities. Title II of the ADA specifically covers services provided by state and local governments (e.g., state and local education agencies). Individuals must meet the definition of disability.	Administration is usually done through the district's Section 504 Coordinator. OT role may vary, but generally addresses accessibility requirements such as accessible facilities; acquisition, adjustment, or modification of equipment or devices (as needed).

TABLE 2.2 (CONTINUED)

Law	General Purpose	Role of OT
Head Start Act of 1964	Provides comprehensive health, education, dental, and social services to infants, toddlers, and preschoolers whose families meet economic guidelines. At least 10% of enrollment must be children with disabilities.	OT role in these programs may include providing services to students with identified disabilities.
Goals 2000: Educate America Act	An education reform law that lists eight national education goals. Students with disabilities are included in the definition of "all students."	OT role will vary.
School-to-Work Opportunities Act of 1994	Joint effort between U.S. Departments of Education and Labor. Students with disabilities are included in the definition of "all students." The purpose is to move the student into the workforce.	OT role includes helping students to make transition to an adult and worker role; participate in state or local level activities to plan this system.
Title XIX of the Social Security Act of 1965 (Medicaid)	Federal program that provides funds to the states for services (medical, social, psychological, and health) to individuals and families meeting income-based eligibility criteria. Programs include the early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21.	OT role with EPSDT includes services in early intervention programs, schools, outpatient clinics, and hospitals. OT role may include billing for services that meet state requirements.

Head Start Act of 1964

Head Start provides expanded opportunities for OT practitioners to serve the needs of children in preschool and community environments. In 1972, Head Start was authorized to make at least 10% of its enrollment opportunities available to preschoolers with disabilities. Children with disabilities are defined in Part B of IDEA, with occupational therapy seen as a related service (45 C.F.R. §1308.3). In addition, states have the discretion of including children experiencing developmental delays, as defined by the state, which is similar to the definition included in Part H of IDEA. Services should be provided in the least restrictive environment through an IEP. The 1994 amendments to Head Start (Pub. L. No. 103–252) created Early Head Start to provide services to infants and toddlers, including young children with disabilities, which will provide "low-income pregnant women and families with children from birth to age 3 with family-centered services that facilitate child development, support parental roles, and promote self-sufficiency" (45 C.F.R. §1304.3(a)(8)). Early Head Start strongly encourages appropriate linkages between Early Head Start programs serving young children with special needs and the Part H system for service and system coordination.

Goals 2000: Educate America Act of 1994

Goals 2000 (Pub. L. No. 103–227) is considered the hallmark of education reform. It is the framework on which all other education legislation (including reauthorization actions) will be based. Designed to help the United States remain internationally competitive, Goals 2000 provides resources to states and communities by using eight national education goals in an effort to help all students reach challenging academic and occupational standards. Included in the definition of "all students" are students with disabilities. Of particular importance to occupational therapy, the first, seventh, and eighth goals relate to OT's contribution to children and family learning, and to the OT practitioner's professional development (see Table 2.3).

School-to-Work Opportunities Act of 1994

School-to-Work (STW) (Pub. L. No. 103–239) is a joint effort of the U.S. Departments of Education and Labor. It is designed to establish a national framework within which all states can create statewide school-to-work "transition" systems that enable U.S. youths "to identify and navigate paths to productive and progressively more rewarding roles in the workplace." The basis of STW is the integration of academic and occupational learning by using school and workplace settings to provide the knowledge, skills, and abilities necessary for the student to move into the workforce.

Title XIX of the Social Security Act of 1965 (Medicaid)

This federally funded program has typically reimbursed for occupational therapy in medical settings. Many states are now seeking Medicaid reimbursement for occupational therapy services in schools (Lewis-Jackson, 1994). Medical but not educational goals have traditionally been reimbursed under Medicaid. This has created confusion for OT practitioners and school

TABLE 2.3—GOALS 2000: EDUCATE AMERICA ACT

The National Education Goals

By the Year 2000

ALL CHILDREN in America will start school ready to learn.

THE HIGH SCHOOL graduation rate will increase to at least 90 percent.

ALL STUDENTS will leave grades 4, 8, and 12 having demonstrated competency over challenging subject matter including English, mathematics, science, foreign languages, civics and government, economics, the arts, history, and geography, and every school in America will ensure that all students learn to use their minds well, so they may be prepared for responsible citizenship, further learning, and productive employment in our Nation's modern economy.

UNITED STATES students will be first in the world in mathematics and science achievement.

EVERY ADULT American will be literate and will possess the knowledge and skills necessary to compete in a global economy and exercise the rights and responsibilities of citizenship.

EVERY SCHOOL in the United States will be free of drugs, violence, and the unauthorized presence of firearms and alcohol and will offer a disciplined environment conducive to learning.

THE NATION'S teaching force will have access to programs for the continued improvement of their professional skills and the opportunity to acquire the knowledge and skills needed to instruct and prepare all American students for the next century.

EVERY SCHOOL will promote partnerships that will increase parental involvement and participation in promoting the social, emotional, and academic growth of children.

systems as they seek Medicaid reimbursement for service delivery for many related services. Yet, there has been a growing recognition that financial responsibility for related services to children with disabilities is to be shared between federal, state, local, and private sources.

SUMMARY

This chapter highlighted IDEA and provided an overview of other legislation that has an impact on occupational therapy services in early intervention, preschool, and school settings. Occupational therapy practitioners' knowledge of the federal, state, and local laws and regulations is essential for effective service delivery.

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CHECKLIST OF QUESTIONS

1. Do you have access to a copy of the federal law or regulations for IDEA? Have you ever used the information to clarify a question you had regarding services under IDEA?
2. Have you read the special education rules from your state's department of education, or state education agency (SEA)?
3. How is occupational therapy defined in your state's special education rules?
4. Have you or your state's OT association developed networks with persons at your state's department of education?

Continuums of Services from Birth Through Young Adulthood

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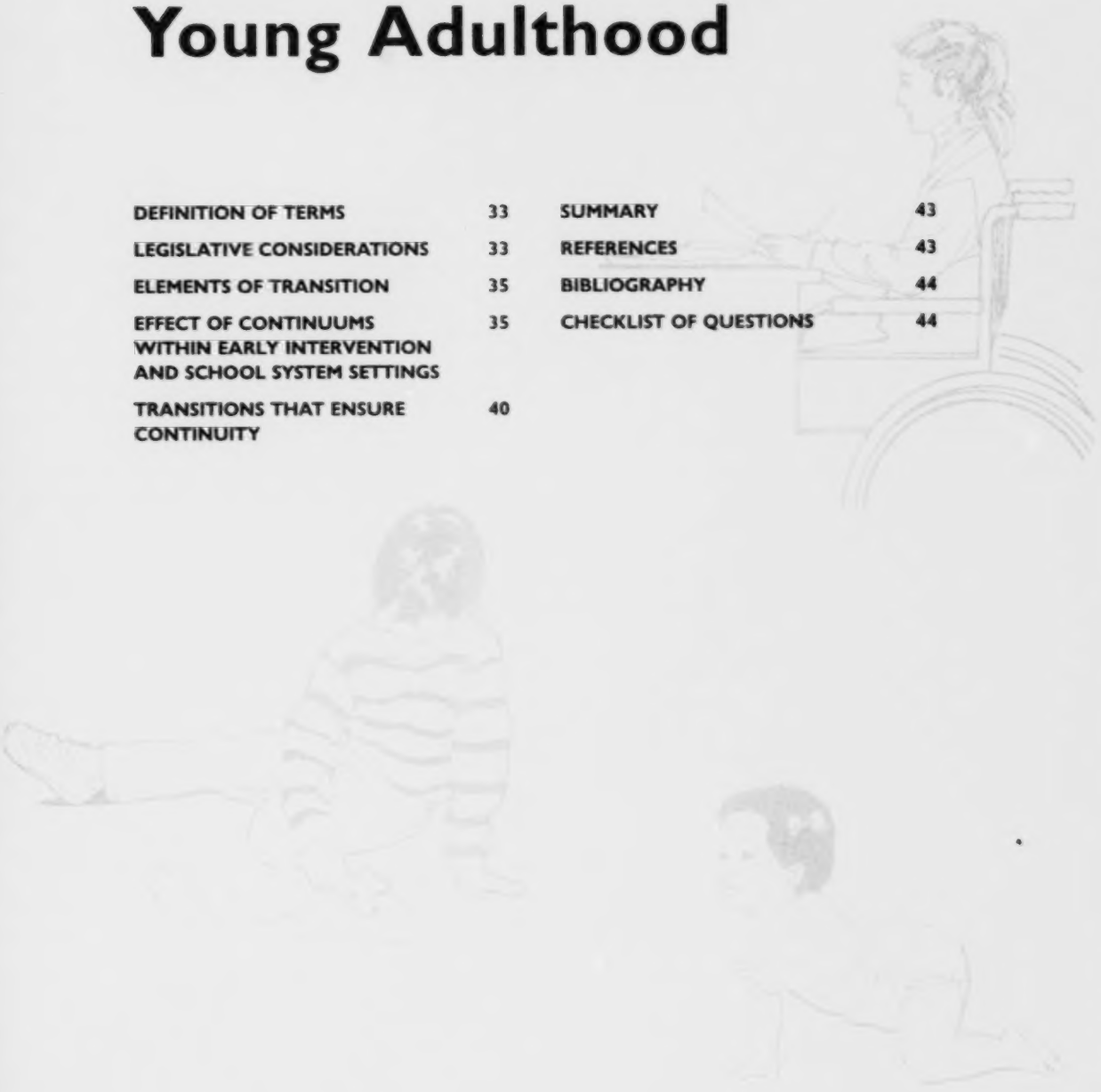

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The concept of a service continuum has been used as the initial organizing theme of these guidelines to set forth the idea that services for children and families should be fluid and changeable. Applying the concept of a continuum affects not only the delivery of OT services in both early intervention and school system settings but also a variety of other components of these settings. To illustrate the continuum, these guidelines describe the transitions within intervention programs, from placement through the achievement of desired outcomes or results. Services and service providers, physical environments, developmental stages and life cycle changes, and team collaboration all contribute to the progression of children and their families along this service continuum.

DEFINITION OF TERMS

A *continuum* can be defined as a series of components that are connected and uninterrupted. This concept allows for different options or different segments along the continuum. In these guidelines, a continuum will be reflected in service delivery options, context or placement options, outcome options, and collaboration opportunities.

Transition refers to a change or a passage from one point along the continuum to another. Transitions can be sparked by changes in the child's chronological age, their developmental level, or their life cycle or disability status.

Service delivery is the provision of professional services to benefit the child and family. In occupational therapy, service delivery is always client centered, involving the practitioner, the child, and the family in a collaborative process of designing and implementing services.

LEGISLATIVE CONSIDERATIONS

While a continuum is not directly addressed in federal legislation covering infants, children, and youths with disabilities, the transition from one program to another is outlined in the Individuals with Disabilities Education Act (IDEA) under Part H and Part B. In Part H programs for infants and toddlers with disabilities, transition is described as "steps to support the toddler with a disability to access services provided under Part B (preschool) when such services are considered appropriate." In Part B under IDEA, transition is defined as

> a coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation (Pub. L. No. 100–476, 20 U.S.C. §1401.19).

This citation directly discusses the transition from one program to another, with emphasis on the design of individual programs that enable a child to reach desired outcomes and to be prepared for the transition from one program to another (see Table 3.1).

TABLE 3.1—IDEA TRANSITION OR CONTINUUM

Issue	Part H	Part B
Transition Services	"Procedures to smoothly move the child from early intervention to Part B services, if appropriate, including how families will be included" (§303.148). A conference must be convened at least 90 days before the child's third birthday or, if earlier, the date on which the child is eligible for the Part B preschool program. A written plan must be established and is included in the IFSP.	"A coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities (including post-secondary education, vocational training, integrated employment, continuing and adult education, adult services, independent living, or community participation)" (§300.18). Services must be based on the student's needs and include instruction, community experiences, the development of employment and other postschool adult-living objectives, and if appropriate, acquisition of daily living skills and functional vocational evaluation. Written plan must be included in the IEP beginning no later than age 16.
Continuum of Alternative Placements	To the maximum extent possible for the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate.	Each public agency shall ensure that a continuum of alternative placements is available to meet the needs of children with disabilities for special education and related services. IEP plan must include alternative placements listed in the definition of special education (see Required Services above), and make provision for supplementary services to be provided in conjunction with regular class placement.

ELEMENTS OF TRANSITION (MOVEMENT ALONG A CONTINUUM)

Transitions or changes are inevitable. In the context of early intervention and school systems, transitions occur as children grow older, move forward or backward on the developmental scale, begin a new life cycle, or experience a change in their disability status. Transitions represent new opportunities and new experiences, but like change in general, transitions go more smoothly and are more successful when the individuals involved work collaboratively to prepare for them. Some transitions occur naturally and require few preparations, such as growing a year older. Other transitions evoke the uncertainty of new expectations and require learning new strategies and developing new relationships, such as moving from a small town to a large city. Some transitions are welcomed and anticipated, while others are dreaded or occur completely unannounced. "Successful transition requires some level of predictability, continuity, coordination, and preparation involving the party making the transition and the persons and places at either end of the transition" (Dunn, Campbell, Oetter, Hall, & Berger, 1989).

Transitions also require constant adaptation. As a child or a family moves through transitions and has new experiences, needs as well as priorities and preferences may change. The different systems as well as the individuals within the systems must be flexible and adaptable to respond to the child's and family's evolving needs. Appropriate support should be provided to families as they and their children experience changes in services, program placements, service providers, and systems. Communication and collaboration are essential to achieve smooth transitions along the continuum.

EFFECT OF CONTINUUMS WITHIN EARLY INTERVENTION AND SCHOOL SYSTEM SETTINGS

As OT practitioners and readers understand the meaning of continuum and the relationship of transitions along that continuum, they will see that there are a variety of continuums and a multitude of transitions children, families, service providers, and agencies encounter in early intervention and school system settings. In fact, the reader could devise a continuum that would illustrate the transitions that occur among the organizing themes in these guidelines (client, context, collaboration, and outcomes).

For the client, the path along a continuum is influenced by the federal legislation that defines who is eligible for OT services and whether OT is a primary or related service, as well as by the setting in which services are being delivered. In early intervention settings, the child's family is the client, and OT is a primary service. In preschool and school system settings, the child is the client, and OT is considered a related service connected to special education services. However, in each of these settings, the OT practitioner may collaborate with and provide therapeutic services to secondary clients such as the teacher, classroom aide, or adaptive physical education teacher. This client continuum reflects

TABLE 3.2—ILLUSTRATION OF CLIENT CONTINUUM

Primary Clients:

- child/student/individual/family
- group or organization
- program or system

Secondary Clients:

- individuals related in some way to primary client
- groups affecting primary client's performance
- system or context that primary client is a part of

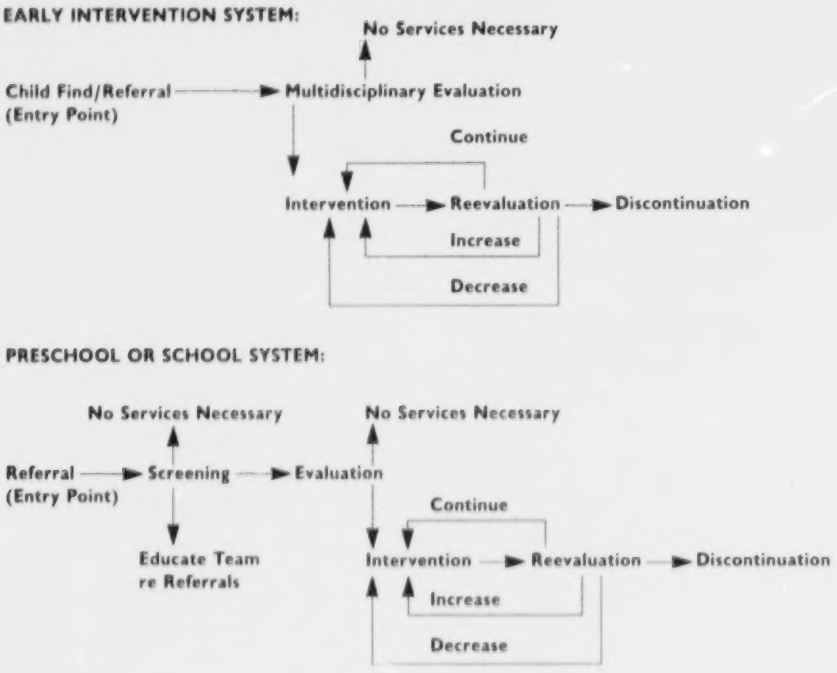
service delivery options that involve collaborative rather than isolated services.

The transitions that move a client along the continuum from primary to secondary services are determined by the desired results or outcomes, which in turn must reflect the child's chronological and developmental age, life cycle, and disability status, and consider systems, models, and contexts relative to client needs (AOTA, 1995) (see Table 3.2).

OT services under IDEA can also be thought of as a continuum, as illustrated in Figure 3.1. The young child with a disability and the family may enter the early intervention system through Child Find and then be referred for OT services through a multidisciplinary evaluation procedure. Referral to the early intervention system can be initiated by the child's physician, the child's parent, or another professional. If OT services are necessary to meet desired family outcomes, as outlined in the IFSP, services are provided using a family-centered approach. OT intervention is provided in the natural environment whenever possible and involves collaboration between the family, caregivers, other service providers, and agencies. As the child accomplishes desired outcomes, services may be decreased or discontinued after a reassessment, as appropriate.

Some children enter special education through the preschool or school system rather than through early intervention. Conversely, some children receive only early intervention services and do not require special education services when they are ready to move out of the early intervention program. Children who enter special education as preschoolers may be referred for OT as a related service. The referral for OT services is usually answered by a screening that may or may not lead to a full evaluation. In some localities, OT services might be provided by the same practitioner to children in early intervention and Part B programs.

FIGURE 3.1. CONTINUUM OF OCCUPATIONAL THERAPY SERVICES UNDER IDEA



Following the evaluation process, the occupational therapist makes recommendations to the multidisciplinary team regarding the child's needs, and the team decides if OT services are needed. Desired outcomes are determined collaboratively among team members and are listed on the child's IEP. When OT services are needed, the therapist determines how the services will be provided. As the child accomplishes the desired outcomes or encounters new needs or challenges, services are adjusted to reflect the changing needs. Discontinuation of services is appropriate as the child or student meets desired outcomes and it is determined that OT services are no longer needed. Referral to other services, as appropriate, can occur anywhere along the continuum. Figure 3.1 shows a continuum of OT services.

As Tables 3.3a and 3.3b show, context can be illustrated along a continuum. IDEA speaks of the least-restrictive environment (LRE) and natural environments when addressing the physical nature of context. But OT practitioners view context in a

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TABLE 3.3A—ILLUSTRATIONS OF THE CONTINUUM OF CONTEXT

Temporal Aspects from UT-3*	Continuum Seen in IDEA
chronological age	birth to 21 years
developmental age	neonate to young adult
life cycle	student, classmate, worker
disability status	acute injury, chronic disability
Environmental Aspects from UT-3*	
physical	home, day care, classroom, work site
social	peers, teacher, support personnel
cultural	educational culture, school rules, day-care policies, family culture

*Uniform Terminology for Occupational Therapy—Third Edition (AOTA, 1994)

TABLE 3.3B—DESCRIPTIONS OF CONTEXT IN IDEA

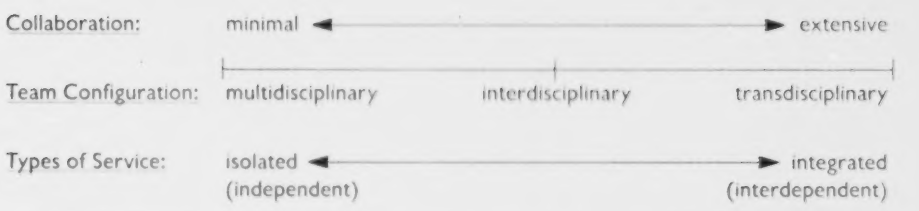
Natural Environments	home, day care, classroom, playground, lunchroom, community center, work site
Least-Restrictive Environment	self-contained classroom, mainstreamed, general education classroom

much broader sense that includes temporal aspects (which involve the child's chronological and developmental ages, as well as life cycle and disability status) along with environmental aspects (which consider physical, social, and cultural influences). Although desired outcomes can determine transitions of context, the provisions in federal law also influence setting and placement options.

Linking services along a continuum of collaboration (see Figure 3.2) can involve examining how a team is configured to provide opportunities for collaboration, assessing how effective a team is, and determining how a team uses collaborative strategies. IDEA provides for coordination of services in Part H by designating a service coordinator. This position fosters interagency collaboration and collaboration among the multidisciplinary team members.

Outcomes can represent an expansive range of possibilities as part of the greater

FIGURE 3.2. TYPES OF COLLABORATION



continuum of OT intervention and are the most difficult to specifically illustrate in a diagram (see Table 3.4). The Individualized Family Service Plan (IFSP) and the Individualized Education Program (IEP) contain desired outcomes or goals and are tailored to each family's or child's needs. Outcomes can involve family-related needs, such as finding day-care services or accessible housing, or child-related needs, such as improved verbal communication skills or greater independence in activities of daily living. Outcomes can also be program-specific as they relate to the delivery of OT services. Desired outcomes might be the improved understanding among team members of the OT practitioner's role in the early intervention or school system setting or the retention of OT personnel to eliminate the pitfalls of staff turnover. Outcomes will be discussed further in a later chapter in these guidelines.

By recognizing that several paths along the continuum have an impact on OT practice in early intervention and school system settings, and by realizing that transition does not take place at one particular point, but is part of a continuous process, the OT practitioner can be better prepared for a variety of transitions. When working with children, practitioners typically focus on the transition from one task to another, from one skill to another. Transition is an essential aspect of OT intervention and should be a concern of OT practitioners during the entire process of intervention. The OT practitioner's recognition that a child's services will change will allow the practitioner to plan for and facilitate natural transitions, while focusing on desired outcomes. Therefore, transition should be viewed not only as planning for the child's discharge or transfer from one service or system to another, but also as influencing every aspect of intervention. When viewed as an aspect of intervention, the initial therapeutic goals and objectives, as well as ongoing goals, are developed and implemented with a sensitivity to the varying transitions that may take place within the delivery of service. For example, while the therapist may have one perspective of the ultimate goals and direction of the therapeutic process, the family and other team members may have a different perspective. The occupational therapist needs to be able

TABLE 3.4—TYPES OF OUTCOMES ALONG THE CONTINUUM

OT Program-Specific Outcomes

- improved understanding of OT role
- retention of OT personnel

Child-Centered Outcomes

- improved verbal communication skills
- increased independence in self-help skills

Family-Centered Outcomes

- locating day care services
- locating accessible housing

to take these varying perspectives into account and accommodate changes in the child's overall program design.

When the OT practitioner considers the continuum of services for a particular child, a number of individuals may be involved: professionals, support staff, and family members on a team that shares the responsibility. A change of one service will affect all other services the child is receiving and may require changes in services by other professionals. Modifications may be necessary regarding (1) who provides the service, (2) how often services are delivered, (3) where the services are provided, and (4) who is financially liable. Modifications may also be required when desired outcomes are not being achieved.

The team as a whole plays an important role in developing and implementing any successful transition, including transitions to new programs. Family members make important contributions to the team regarding the choice and configuration of programming. On an individual level, it may be essential for the occupational therapist to contact the therapist who will work with the child at the new facility to ensure a smooth transition and continuity of service delivery.

TRANSITIONS THAT ENSURE CONTINUITY

Some changes are predictable. For example, a child will move from a preschool program to a program for school-age children. Other changes may not be predictable, such as when individual therapy is changed to group therapy, when therapy provided to a child outside of the classroom is moved into the classroom, when a therapist is replaced, or when services are terminated. Any change in therapeutic situations

may be disruptive to children and their families. However, predictable changes may be easier to deal with than those that are not expected. The therapist's professional responsibility is to help make changes in therapeutic programming as smooth as possible so that the care remains meaningful and effective.

Occupational therapists and certified OT assistants are in an ideal position to facilitate continuity because they view the child within the context of his or her environment, or holistically. The following strategies may be used by practitioners to facilitate smooth transitions:

1. Address issues of inevitable change from the onset of intervention. Then, when change occurs in the child's program or services, it will not come as a surprise. The practitioner should be aware of the need for change and of his or her own feelings about issues of change.
2. Develop effective and consistent communication with the family, the service coordinator, and all staff who work with the child so change can be discussed openly in an atmosphere of trust and mutual respect. The team should hear all perspectives, not just those of one member.
3. Plan transitions in services carefully with other professionals whenever possible so that consensus can be reached regarding the change and all involved can communicate similar perspectives regarding the rationale for the change. Knowledge of available resources can facilitate the planning process. When change occurs suddenly, professionals should work together as much as possible to ensure that all are working toward the same goal.
4. Articulate to parents, care providers, and the child a rationale for and the potential benefits of change. Everyone involved should understand why the change is occurring and how this change will help the child and family reach their goals.
5. Understand and appreciate the complexity of systems that serve children and their families, the organizational structures, and the methods of reimbursement within the broader context of community and society. Also consider the influence of state and federal legislation and regulations.
6. Examine and reflect on change as a part of professional growth. Accepting the realistic limitations of what can be done for a client and of the outcomes is important for therapy practitioners. Such introspection can promote personal and professional growth.

Understanding how change may effect continuity of care is of paramount importance. The site of the services or the type of services delivered may change, and it is helpful to examine each change individually.

A change in the site can occur while the service delivery model remains the same. An example would be when a child moves from one preschool program to another, or from preschool to elementary school, while continuing to have the same services provided, such as individual occupational therapy. Because this type of change is so apparent, it is frequently given more attention than other types of changes.

A change in the type of service involves changing the way in which services are provided. An example is therapy that is initially provided individually outside of the classroom and then changes to services integrated into the classroom. Another example is a child's transition from one program to another, such as when a child goes from the neonatal intensive care unit to an early intervention program, or from a mainstreamed classroom situation to a prevocational program. When these changes can be predicted, they can be prepared for more easily. Many systems have formalized methods of making these types of transitions smoother. The occupational therapist must become aware of what is in place within the system and must take an active role to include OT in this process. The therapist who is currently working with the child should avoid making promises about what will occur in the new setting. While promises may be made with good intentions, they can build unrealistic expectations.

Often, changes occur in both the site and type of intervention simultaneously. When intervention is provided at home, it is generally done on an individual basis. When the child goes to a preschool program, intervention may be provided in another manner, such as in a group or within the classroom. This approach may be perceived incorrectly as a loss of services by the family or other staff members. The therapist can help by describing the goals and benefits of this type of programming change so that it can be seen as positive (indicating growth) rather than as negative (loss of services).

Other changes in the child's programming are more unpredictable but have an impact on the child and family. Such changes should be thoroughly discussed with the family and child. Transitions can be difficult for practitioners as well.

Occupational therapists and certified occupational therapy assistants have an important role in facilitating successful personnel changes. If the transition involves a change in therapy practitioner, as many do, it is helpful for the practitioners to communicate with each other to exchange information, identify important areas of concern, and share information about the child's intervention. For the practitioner who will no longer be working with the child, it is easy to perceive that responsibility has ended when he or she leaves. However, the practitioner must accept the professional responsibility to communicate with the new practitioner who will be working with the child. This communication includes written reports and notes that follow the child, and oral communications to transmit one's understanding of the child and potential future goals. Similarly, the newly assigned practitioner must read the child's complete file.

The newly assigned practitioner should also communicate with other people who have a distinct knowledge of the child and family. These people may include, but are not limited to, the parents and significant care providers, teachers, previous therapy practitioners, social workers, and service coordinators. This information will give the practitioner a clearer picture of the child. Each practitioner wants to establish his or her own goals and independent picture of the child so communication can be enriching and ensure continuity of care. If

this communication is not part of the transition, important information can get lost. For example, a child has been receiving related services for several years, and each year the OT practitioner has changed. Year-end reports have been filed in the child's main file in the district office but they have not been shared with the newly assigned therapist. At the end of each year for the past two years, each therapist has recommended the use of computers to teach beginning typing skills to compensate for difficulties with handwriting. Although each year the newly assigned therapist received the annual goals that had been written in the IEP, he or she did not read the reports or communicate with the previous therapists. Computer skills were included in the annual reports, but they had not been specifically written into the IEP. At the end of three years, the file contained three recommendations that the child use a computer in intervention, but no one had implemented the recommendation or was aware that it had been listed before. Although the transition outwardly seemed smooth, information was lost because of the lack of good written and oral communication between the various occupational therapists who treated the child each year.

Discharging a child from intervention can be emotional for all parties. Children and practitioners become attached to each other, and practitioners can easily lose perspective on what goals have been reached and what goals are still to be met.

Additionally, parents generally see intervention as important to the child's growth. Continued intervention frequently indicates to them that the child has potential for growth and change. Therefore, the decision to discontinue a child's services may not be well received. The occupational therapist must have an appropriate rationale for the change in service and be able to back up the decision with data, either through testing, observation, or both. Information from the teacher and other professionals working with the child should contribute to the decision to discontinue services.

SUMMARY

This section discussed facilitating transitions in service for children from birth through young adulthood. It highlighted the changing needs of children and their families over time and the resulting changes in services. Occupational therapists and certified occupational therapy assistants can play an integral role in the process by ensuring that therapy services are provided in a continuous and integrated manner. Examples of various types of transitions are provided, with suggested strategies to facilitate ease and continuity. The role of the occupational therapist is important in ensuring that a child and his or her family receive appropriate support through the modification and adjustment of services.

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CHECKLIST OF QUESTIONS

1. What procedures does your agency use to ensure smooth transitions for children
   - between program placements (preschool to kindergarten)?
   - between service providers (i.e., teachers, therapists, etc.)?
   - between systems (early intervention to school system)?
2. Consider the continuum of collaboration within your agency. Can you suggest ideas to help your agency develop greater collaboration?
3. Consider one child you have worked with this year. What transitions has he or she experienced this year? Have these transitions occurred smoothly? Why or why not? What strategies could you use as an individual service provider to make transitions smoother?

The Client

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In early intervention and school system practice, OT practitioners collaborate with children, family members, program personnel, other service providers, school administrators, and a variety of community agencies. This collaboration frames the relationship that is established when OT services are delivered to the client. This chapter provides information about using a client-centered approach to OT service delivery. While practitioners often recognize the child, student, or family as a client, this chapter broadens the scope of the term to include the other individuals, programs, and systems that interact with OT practitioners to achieve program goals or outcomes. By viewing service delivery in relation to the client, the OT practitioner can be flexible and move through a continuum of services and interventions.

DEFINITION OF TERMS

Client refers to a person, group, program, or organization for whom the OT practitioner is providing services (AOTA, 1995). Under Part B of IDEA, the child becomes a client only when he or she has met special education eligibility criteria. Under Part H, the family of the infant or toddler with a disability is the client.

Client-centered service delivery is "an interactive approach to service that considers systems, models, and contexts in making decisions that focus on the client's needs and that engages the client as a participant" (AOTA, 1995).

Family-centered services recognize that the infant or child with a disability is a member of a family. The needs and priorities of the family are considered when services are designed and provided.

Interactive describes the exchange of ideas between individuals. An *interactive service delivery approach* implies that the OT practitioner and the client collaborate by exchanging information and responding to each other's concerns.

A *system* is "an organized entity of interdependent components or principles that provides a structure by which to work and function" (AOTA, 1995). In this document the systems referred to are the early intervention system and the school or educational system. Each system has a mission, specific goals and objectives, recognized personnel, and shared values and beliefs. As they provide services to clients within these systems, OT practitioners need to recognize the importance of working with others in the system to keep it intact and moving toward achieving its stated mission.

LEGISLATIVE CONSIDERATIONS

In Part H of IDEA, infants and toddlers with disabilities are defined as those from birth through 2 years of age who are experiencing developmental delays or who have been diagnosed to have a physical or mental condition with a high probability of resulting in a developmental delay and, therefore, need early intervention services. In addition, at the state's discretion, children at *risk* for developmental delay may be identified as eligible for early intervention services. Thus, Part H of IDEA considers occupational therapy as a primary service.

In Part B of IDEA, children and youth with disabilities are defined as those ages 3–21 who meet one or more of thirteen disability categories and who, by reason thereof, need special education and related services (34 C.F.R. §300). In addition, at the state's discretion, children ages 3–5 who have delays in physical, cognitive, communicative, emotional, social, or adaptive development and who need special education and related services may also be included in this definition. In Part B, children must first meet the eligibility criteria for special education before they can be eligible to receive occupational therapy as a related service. Table 4.1 compares Part B and Part H eligibility requirements.

Children who need special education and related services are identified by their local education agency (LEA) for services provided under IDEA. It is important to note, however, that LEAs cannot deny needed services to children with disabilities who do not meet the specific criteria for special education and related services under IDEA. Section 504 of the Rehabilitation Act of 1973 (Section 504), a nondiscrimination statute, protects the rights of individuals with disabilities in programs and activities that receive federal financial assistance, including state and local education agencies.

Section 504 states that any student who is currently disabled cannot be denied or excluded from services if the services are needed for the child to benefit from a free and appropriate public education (Gallegos & Rodriguez, 1991). In Section 504, the definition of a disabled person is much broader than the categories of disability specified in IDEA. Section 504 identifies a child as disabled if he or she has or have had a physical or mental impairment that substantially limits a major life activity, or who are regarded as having such an impairment (Gallegos & Rodriguez, 1991). Although the demand for OT services in public schools that are provided under Section 504 varies across the country, its application contributes to the scope of practice for occupational therapy practitioners working in public schools.

CLIENTS ALONG THE CONTINUUM OF SERVICE DELIVERY

The OT practitioner is faced with the responsibility of determining exactly *who* the client is and who else, in addition to the identified client, may receive OT services. In Part H, IDEA specifies that OT services for early intervention must be family-centered and can be delivered as a primary service. The law also provides for service coordination among providers, leading the OT into collaborative relationships that allow for sharing information and achieving a mutual commitment to the outcomes in the individualized family service plan (IFSP).

In Part B of IDEA, occupational therapy is a related service that is connected to special education. Although service coordination is not mandated under Part B, OT practitioners, along with other related service providers, recognize collaboration and coordination as best practice. As related service providers, OT practitioners join multidisciplinary teams that share a mutual commitment to the educational goals that are outlined in an individualized education program (IEP).

TABLE 4.1—ELIGIBILITY REQUIREMENTS UNDER IDEA

Part H	Part B
Infants and toddlers birth through age 2 who are experiencing developmental delays in one or more of the following areas: • cognitive development • physical development • communication development • social or emotional development • adaptive development or Have a diagnosed physical or medical condition that has a high probability of resulting in developmental delay. May include, at a state's discretion, children from birth through age 2 who are at risk of having substantial developmental delays if early intervention services are not provided.	Children with disabilities evaluated ... as having • mental retardation • hearing impairments, including deafness • speech or language impairments • visual impairments • serious emotional disturbance • orthopedic impairments • autism • traumatic brain injury • other health impairments • specific learning disabilities • deaf-blindness/multiple disabilities and who because of these impairments need special education and related services. May include at a state's discretion, children ages 3 through 5 who are experiencing developmental delays, as defined by the state.

Throughout the provision of services, including the evaluation and the development of intervention strategies, the OT practitioner certainly must look at the infant, toddler, or student with a disability. But the OT practitioner must look beyond the child with a disability to the individuals and groups that surround the child, that have a personal interest or an emotional investment, and that participate in the child's environment (or context). These may be family members, friends, health care providers, respite providers, or school personnel. All can be considered interdependent stakeholders in the child's growth and development.

Envisioning the child's environment as a wheel, the potential secondary clients of OT services encompass all those with a stake in the child's functional performance (see Fig. 4.1 and Table 4.2). Although the child with a disability (and the family in early intervention) is clearly the hub or central focus of the service, each individual or group represented on the spokes of the wheel are stakeholders. The stakeholders

are an essential part of the wheel's ability to function, and the interface that occurs among them forms the rim of the wheel. Their common goals and collaborative efforts assist the child to move forward along a developmental path. All involved have an investment in the successful functional performance of the child with a disability.

Although the child or the child and family may be the primary clients, the stakeholders, by virtue of their interdependent roles, may be considered the secondary clients of OT services. Throughout the child's life, from infancy through preschool through graduation, these secondary clients should be considered in decisions regarding OT services. As children mature, the scope of their environment expands. Environmental factors such as family makeup, day-care settings, or medical intervention will cause the makeup of the individuals and groups who are among the stakeholders to change and grow as well. OT practitioners must be aware at all times of the changes in the child's environment to ensure that services remain relevant and achieve their greatest impact.

INTERACTIONS WITH CLIENTS

Whether occupational therapy is provided as a primary service or as a related service, the OT practitioner functions as a member of a multidisciplinary team. Collaboration of team members is an important component in the delivery of all early intervention and school system services. When

FIGURE 4.1. PRIMARY AND SECONDARY CLIENTS OF OT SERVICES

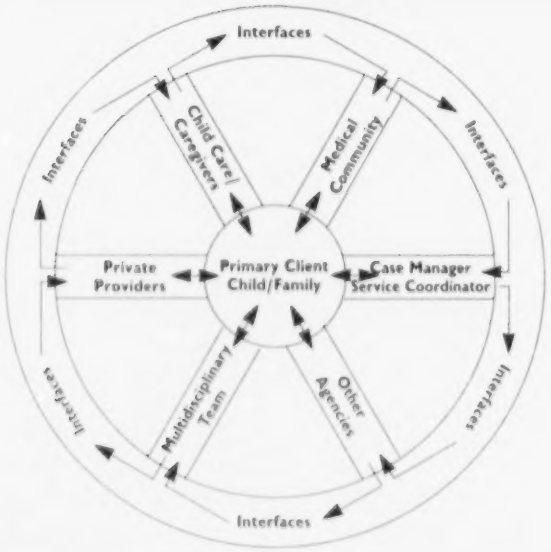

TABLE 4.2—SECONDARY CLIENTS—OTHER STAKEHOLDERS

Early Intervention	School System
Family physician	Family
Nurse	Teacher
Psychologist	Principal/School administrator
Physical therapist	Social worker
EI provider	Psychologist
Speech-Language Pathologist	Classroom aide
Day-care provider	Adaptive physical education teacher
Service Coordinator	Physical education teacher
Social worker	Peers/Classmates
Funding systems	Speech-Language Pathologist
Peers, classmates	Physical therapist/PT assistant
Community programs	School nurse
	Parent-Teacher Association
	Funding system
	Vocational rehabilitation specialist

the team determines that OT services are necessary for a particular child or family to reach program goals, the OT service provider must determine how best to meet those identified needs.

Rather than viewing OT services within the confines of direct service, monitoring, or consultation, these guidelines stress the concept that the OT client changes or secondary clients evolve depending on the demands within the environment, the continuum of services, and the expected program outcomes.

For example, consider a family of two young parents with a healthy toddler and a 6-month-old baby boy born with Down syndrome. When assessed by the early intervention team, the baby is determined to have delays across all domains (cognitive, motor, adaptive, psychosocial). Both parents work outside the home, so child care is an important part of the baby's environment. A grandmother cares for the baby during the day, but the parents would like to place him in the same child-care facility as his sibling when he becomes eligible at 12 months of age.

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At the IFSP meeting, the parents expressed concerns about their baby's reluctance to move to explore his environment, his difficulties with feeding, and his inability to interact effectively with toys. The team (including the parents and grandmother) agrees that this child demonstrates a need for early intervention services. Although the grandmother is somewhat unsure and hesitant, the parents are eager for the baby to receive intervention. The team determines that the teacher and the occupational therapist would be the most appropriate service providers. In addressing this family's needs, the OT recognizes that she will be collaborating and interacting with several clients. She may provide services to the child, his parents, his grandmother, his teacher, and eventually the child-care providers at another facility. These services may include demonstrating movement facilitation techniques, designing sensorimotor play activities, and collaborating with the family to develop a feeding program. As the child develops and new program outcomes evolve, the OT may collaborate with and interact with other clients, such as the physical therapist, preschool teacher, school nurse, or speech-language pathologist.

In a second example, the OT practitioner in a school setting may determine that a 6-year-old child in first grade has the ability to develop better written communication skills by improving his grasp and visual-motor skills. The child is the client and may require OT intervention to enhance hand strength, finger dexterity, fine motor planning, and laterality. The OT practitioner may determine that the family and the teacher are secondary clients who could collaborate in achieving the desired outcomes by providing activities to practice written communication activities at home and in the classroom.

A third example is a child who attends a preschool program for children with visual impairments and may already be receiving special education instruction to enhance his tactile processing skills as well as to enhance his awareness of his spatial environment for better mobility. However, his teacher may become a client of OT services when she expresses concern about the child's difficulty with transitions between activities and his inability to tolerate the noisiness of the classroom. These difficulties interfere with his attention to classroom tasks as well as with his willingness to attempt new activities or change classroom tasks. In this case, the OT practitioner may provide information, including coping strategies about children who display possible auditory defensiveness and temporal disorganization. Thus, the child is not the primary client; the teacher is receiving OT services to assist her in enhancing the child's performance within that school setting. If the child's needs persist despite the strategies the teacher is able to provide, the child may eventually become the client, and the OT practitioner might then have two clients with different, but related, needs. In this same example, the classroom aide may become a secondary client, as she is responsible for helping this child participate in music activities. It would certainly be important to share strategies with her to help the child cope with the auditory input of the music activities.

In each of these instances, the OT practitioner is providing OT services, but the specific intervention techniques may be very different according to the needs of the client and in relation to the desired program outcomes.

Table 4.3 further illustrates how the OT practitioner may provide services to a variety of clients, how those clients may change based on the issues, and how the clients achieve the expected program outcomes. In this example, the student in a school system faces challenges with fully participating in his classroom program. As each of the specific problems are described by the team, those problems are connected to a program objective. As the OT practitioner reflects on the program objectives, she determines who besides the student may assist in achieving those objectives. In some situations, the student and OT practitioner alone will address the objective, while in other situations, the practitioner will collaborate with several clients. After determining who the client is in each case, the OT practitioner and the clients design specific interventions that are aimed at achieving the desired outcomes.

Each of these examples describes a continuum of OT interventions that are provided to various clients and that comprise many different services. The services address specific issues brought forth by team members. However, the OT practitioner also may be asked to provide services to a larger system such as a school system or local agency. In viewing the system as a client, the OT practitioner looks at more general needs. The purpose of such services would be to improve the effectiveness of the whole system. Such services would not address the needs of specific people, but would look at the needs of generic groups within the system (AOTA, 1989b).

For example, OT services might be used to develop long-range goals for an organization. They might also be used to assess the architectural needs for accessibility or to develop an overall curriculum to meet a broader set of needs such as vocational readiness (AOTA, 1989b). Therefore, when the OT practitioner is approached by a school or agency administrator to provide these broad services, the system is the client and receives the overall benefit of OT intervention.

By keeping in mind who the actual client is, the OT practitioner can design and implement specific interventions with the client to meet client needs. Recognizing that clients may change over time and that new clients may develop allows the practitioner to change the intensity of service delivery and the focus of intervention, thereby creating greater flexibility for OT services to meet desired program outcomes.

Client Roles and Responsibilities

When entering a collaborative relationship, each participant assumes responsibilities for maintaining that relationship. It is important for the OT practitioner to remember that a client may have responsibilities that take precedence over those of the team and may potentially conflict with the client's role. By keeping this potential conflict in mind, the OT practitioner can realistically plan strategies to develop and maintain collaborative relationships with each client.

TABLE 4.3—OT SERVICES TO CLIENTS

Issue	Program Objective	Client	OT Intervention
Student cannot access computer keyboard.	Student will use computer to produce written work.	Student	Occupational therapist provides adaptive equipment (head pointer, key guard, etc.) and instructs student in its use.
Student is limited in participation in gym class.	Student will participate with peers in physical education.	Physical therapist (PT) Physical education (PE) teacher Adaptive PE teacher (APE) Classroom aide Peers	COTA collaborates with PT and PE teachers to adapt PE curriculum to enhance student's participation. Provides adaptive equipment when necessary. Assists with modifying activities, soliciting peer support, and training classroom aide.
Student cannot independently access student locker.	Student will be responsible for retrieving materials and supplies from the locker for classroom activities.	Principal School janitor Aide Student	Occupational therapist designs plan to reorganize locker to enhance student's ability to access materials, then collaborates with school principal to modify design of the locker. Therapist collaborates with school janitor to move shelves in the locker, replace lock mechanism, move door to open in opposite direction, and place hooks on door rather than

TABLE 4.1—OT SERVICES TO CLIENTS (continued)

Issue	Program Objective	Client	OT Intervention
			inside locker. Therapist collaborates with student and aide to determine the effectiveness or need for further modifications.
Student has difficulty participating in art class.	Student will produce art projects according to specified curriculum.	Art teacher Student Classroom aide	COTA collaborates with art teacher to design activities to meet curriculum goals while considering student's physical needs. Together they investigate computer art activities as well as develop sensory experiences to allow artistic expression. Classroom aide is instructed in how to assist student, while student is given opportunities to choose among greater variety of activities.
Student requires assistance for toileting.	Student will be safely and appropriately assisted in the bathroom to enhance independence while recognizing needs.	Student Student's aide Principal School janitor	Occupational therapist collaborates with PT in instructing student's aide on how to perform standing pivot transfer giving moderate assistance to the student. Therapist discusses with principal the need for modifications to the school bathroom and collaborates on the redesign. Therapist

TABLE 4.3—OT SERVICES TO CLIENTS (continued)

Issue	Program Objective	Client	OT Intervention
			also collaborates with school janitor on specific equipment needed and where it can be purchased.
Student is unable to access playground equipment using a walker.	Student will participate in active play during recess.	School principal Parent-Teacher Association (PTA)	Occupational therapist collaborates with principal and PTA to investigate playground modifications to allow greater access for students with disabilities. Therapist presents information regarding accessible playgrounds and provides PTA with local contacts for necessary adaptations.

It cannot be overemphasized that OT practitioners working in early intervention programs and in school settings should develop strong working partnerships with parents and families. Frequent, ongoing communication with families can provide valuable insights into variations in a child's or student's performance at home, and can be crucial in ensuring that desired outcomes are met at school. While providing service to children and families, OT practitioners will encounter parents in varying stages of grief, in varying positions of advocacy for their child, and in varying parental roles (educator, counselor, mentor, friend). Families and caregivers are responsible for making decisions for their children. Their knowledge about and concern for their children must be respected even if their beliefs differ from those of the OT practitioner. Practitioners must recognize the different roles parents and families assume and must support them in an effort to achieve a collaborative relationship.

OT practitioners must, however, be cautious about expecting a certain level of participation by a family. Some families can and want to be interventionists. Others may be doing their best just to care for their children and get them to school every day. No family or caregiver should be viewed as disinterested or uninvolved. The level of a family's participation is not a

measure of the quality of the parenting skills or of the relationship with their child. Nor is their level of involvement a reflection of the ability of the professionals involved. Families may vary in their ability to participate as their life cycles change. OT practitioners should be responsive to any level of involvement a family chooses and should be nonjudgmental.

Interdisciplinary team members assume the responsibility of maintaining an effective, collaborative, working group. As team members, they must listen carefully to each other, must be open and honest, and must be committed to one another's growth. Team members should know and be able to articulate their own strengths, limits, and needs. When team members work together on behalf of the child and family, intervention can have a stronger impact than when team members work independently. Members of the interdisciplinary team share responsibility for program outcomes as outlined on the IEP or the IFSP.

Other agencies, programs, and systems that receive OT services assume a responsibility to support a collaborative relationship. Good communication is the basis of professional trust that forms the foundation of interagency and interprofessional collaboration (AOTA, 1989a). This collaboration includes maintaining mutual respect, even when specific beliefs or values are not shared.

Reimbursement Systems

Although they may not view payment systems as potential clients, OT practitioners need to maintain collaborative relationships with the systems that interface with their services. Various payment systems provide reimbursement for occupational therapy services in early intervention and school system practice.

In the IDEA legislation, the U.S. Congress showed that to meet the needs of infants and toddlers with disabilities and to minimize their potential for developmental delay, the U.S. government should provide financial assistance to states to facilitate the coordination of payment among various public and private funding sources. IDEA made grants available to the states for personnel, technology, educational media, and materials through state and local education agencies. In 1989, the Health Care Financing Administration (HCFA) created an opportunity for early childhood intervention programs and for local education agencies to be designated as providers in fulfillment of state matching requirements for Medicaid programs. Since then, many states have created programs that allow local education agencies to identify Medicaid-eligible special education students ages 3 through 21 and to bill for related services, including occupational therapy. In early intervention, preschool, and school programs, parents must give their consent before agencies can bill that family's private health insurance or Medicaid, if eligible, for reimbursement.

When accessing a family's private health insurance, schools may not bill the family for any deductible amount and may not bill for any excess cost above what the insurer pays. In addition, the courts have maintained that when the cost for services described in an IEP reduces the family's private health insurance policy's lifetime

cap, that expense must be reimbursed by the school system to ensure that the education provided to the child is free (Education of the Handicapped Law Report, 1985–1986). If parents refuse to give permission to bill the private insurer, the school is responsible for providing the service at no cost. However, as more and more families receive health benefits through managed care programs, it may be more difficult for schools to access private health insurance benefits.

Documentation required for third-party reimbursement may be more extensive and more medically oriented than that usually done for school-based services, which must assist the child to benefit from special education. In addition, third-party reimbursers usually require a physician's referral to establish medical necessity before approving payment. The use of current procedural terminology (CPT) codes to describe services provided and the requirement of an international classification of diseases–ninth revision (ICD–9) code to further determine medical necessity of OT intervention also complicate the documentation and billing process. It is important for OT practitioners to be aware of how third-party payment works in their state, and particularly of how the financial incentives allowing reimbursement are structured.

In schools, occupational therapists must be responsible for ensuring that decisions regarding OT services for children are based on appropriate evaluation data and team input, and that services are related to the child's ability to benefit from his or her education. Decisions regarding OT services must be driven by best practice and not by the reimbursement structure.

SUMMARY

This chapter examined OT service delivery by broadening the scope of who the client of OT services is. In early intervention, OT services are family-centered and are considered a primary service. In school system settings, OT services are child-centered and are considered a related service. Both involve collaboration among the individuals who make up a multidisciplinary team. This chapter moved beyond the typical scenarios that consider the child as the only client, thus allowing the OT practitioner to use more creative and flexible approaches to service delivery to meet the child's and family's changing needs.

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CHECKLIST OF QUESTIONS

1. How does your state or agency provide OT services to children and families in early intervention programs? According to this method of service delivery, who is the client for your services? Are you providing services to anyone else?
2. Do you know your state's eligibility criteria under which your clients are receiving OT services
   - under Part H of IDEA?
   - under Part B of IDEA?
   - under Section 504 of the Rehabilitation Act?
3. If you are providing services within an inclusive environment, who are your clients? Who are other potential secondary clients?

The Context of Intervention

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Home, day care, school (including the lunchroom, playground, field trips, and classroom), and other community settings in which children typically participate (the YMCA, a library) are natural performance settings for children. These natural settings offer unusual and special challenges for occupational therapy. It is essential for OT practitioners to understand the contexts in which they provide services. In making decisions about occupational therapy, therapists may skillfully apply models, theories, or frames of reference, but they are not sufficient to establish responsibility in today's practice arenas. To maximize OT's therapeutic potential, services must interface with a model that reflects the OT work environment. As Figure 5.1 illustrates, occupational performance results from this interactional relationship. To be effective, service delivery for each individual must be designed to reflect this interaction.

This chapter will examine the influence of context (as defined within AOTA's "Uniform Terminology for Occupational Therapy—Third Edition," 1994) on a child's performance areas in early intervention, preschool, and school programs. The educational setting will be discussed as it relates to curriculum and educational design. The early intervention setting may include the neonatal intensive care unit (NICU), home, day care, special classroom, Head Start, or other settings in which infants and toddlers may be.

FIGURE 5.1. RELATIONSHIPS IN OCCUPATIONAL PERFORMANCE

Source: Law, Cooper, Letts, Rigby, Stewart, & Strong, 1994.

DEFINITION OF TERMS

Performance contexts are defined as situations or factors that influence a person's engagement in desired or required performance areas. Performance contexts can be divided into two aspects: temporal and environmental.

Temporal aspects include the child's chronological age, developmental stage or phase, current place or phase in the life cycle, and place in the continuum of disability.

Environmental aspects are more broad and include physical (nonhuman) elements, social influences and expectations, and cultural aspects such as customs, beliefs, and laws.

Performance areas are broad categories of human activity that are typically part of daily life. They are activities of daily living, work and productive activities, and play or leisure activities.

Least-restrictive environment (LRE) as used in Part B of IDEA ensures that children with disabilities are educated with children who are not disabled to the maximum extent appropriate. It also ensures that they are removed from general education only when the nature or severity of their disabilities, even with supplementary aids and services, prevents satisfactory achievement in general classes (34 C.F.R. §300.550). LRE has been interpreted differently over time (i.e., mainstreaming, full inclusion).

Mainstreaming and *full inclusion* are terms frequently used when referring to general education opportunities for children with special education needs. For this document, the term *mainstreaming* refers to the educational team's recommendation for a special education program as the student's primary placement and includes opportunities in the general education setting. *Full inclusion* refers to a program that is primarily general education, with special education resources and supports provided as needed.

Natural environments in Part H refers to those settings that are "natural or normal" for the infant's or toddler's peers who do not have disabilities. To the maximum extent possible, early intervention services are to be provided in those natural environments, including the home and community settings (34 C.F.R. §303.12(b)).

Environment fit, as used within OT literature, refers to the interaction of the performance areas, performance components, and performance context, which then influence the success of an individual's performance (AOTA, 1994).

LEGISLATIVE CONSIDERATIONS

This section will discuss the role of OT practitioners and the environment in relation to various pieces of legislation that shape school and early intervention practice. Table 5.1 provides the definition of OT from IDEA regulations.

IDEA, Part H

Occupational therapy in early intervention can be a primary service under Part H that is specifically for infants and toddlers (birth through 2 years). OT services in intervention can be provided with or sepa-

TABLE 3.1—OCCUPATIONAL THERAPY UNDER IDEA

	Part H	Part B
Occupational Therapy	A primary service for eligible infants and toddlers from birth through age 2 who qualify for early intervention services that "are designed to meet the developmental needs of the child ... and the needs of the family related to enhancing the child's development" (§303.12 (1)). "Includes services to address the functional needs of the child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include • identification, assessment, and intervention • adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills • prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability" (§303.12 (8)(i)(ii)(iii)).	A related service for eligible students ages 3 through 21 who require "... such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education" (§300.16(a)). "Includes • improving, developing or restoring functions impaired or lost through illness, injury, or deprivation • improving ability to perform tasks for independent functioning when functions are impaired or lost • preventing, through early intervention, initial or further impairment or loss of function" (§300.16 (5)(i)(ii)(iii)).

rate from any other health or educational services the child and family might need. The law requires that services be provided in natural environments to the maximum extent appropriate. Physical environments for services include child-care settings, home, YMCA, libraries, or restaurants. Services may also be provided in the NICU or hospital because of the need for medical care. Early intervention team members should develop the criteria that assist in the child's transition from services in the NICU or hospital to services in the natural environment.

IDEA, Part B

Within Part B (children and youth ages 3 through 21), occupational therapy is a *related service*. OT services are provided to assist children and youth with their daily participation in their educational programs. OT should not be viewed as a part of the curriculum but as a resource to allow the student to function within the school routine. The amount and intensity of services should increase or decrease according to the changes in educational demands and in a student's performance.

Part B refers to the least-restrictive environment (LRE), which means that, to the maximum extent appropriate, children who have disabilities should be educated with children who do not have disabilities. Special education is a service, not a place, so instructional and related services should be determined by the student's performance within the LRE.

When OT services are provided within the context of the child's educational program, service delivery occurs where the need occurs, unless special circumstances are present. Service delivery could occur in the playground, bathroom, lunchroom, art class, field trips, bus, general education program, resource program, locker room, or community. In special cases, such as for isolated skill development, medical needs, or for confidentiality, services may be provided in a separate room. However, the therapist should consider these isolated services as short-term and should work toward service delivery within the school environment. Because many children who receive special education services have difficulty generalizing concepts, providing their occupational therapy services in isolation and expecting them to use the skills appropriately within the school routine may be unrealistic and ineffective.

Other Legislation

Additional legislation, such as the Head Start Act, Section 504 of the Rehabilitation Act, and the School-to-Work Opportunities Act, can also influence the physical environment for service delivery. Table 5.2 defines the physical environment for service delivery under IDEA. The temporal aspects, such as the age and developmental phase of the child receiving services, are also controlled by various federal and state rules and regulations.

ASPECTS OF PERFORMANCE CONTEXTS

This section elaborates on performance context as defined in "Uniform Terminology for Occupational Therapy—Third Edition" (AOTA, 1994) and discusses two aspects of performance context, temporal and environmental, in more detail, along with examples illustrated in Table 5.3.

TABLE 5.2–ENVIRONMENT OR CONTEXT UNDER IDEA

Part H	Part B
To the maximum extent appropriate, services are to be provided in natural environments, including home and community settings, in which children without disabilities participate.	To the maximum extent appropriate, children with disabilities are to be educated with children who are not disabled, and that ... removal of these children from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. (Least-restrictive environment [LRE].)

TABLE 5.3–EXAMPLES OF CONTEXT

Temporal Aspects	Part H (Birth–3 Years)	Part B (3–5 Years)	Part B (6–21 Years)
Developmental	Neonate Infant Toddler	Infant level Preschooler	Infant level School age Young adult
Life Cycle	Parenting cycle (important for infant and toddler growth); home to community transitions (child care, grocery store, etc.)	Parenting cycle; teacher and peer influence; home to preschool transitions	Parenting cycle; greater peer influence; school to community to work transitions
Disability Status	Acute, chronic, terminal Mild, moderate, significant	Acute, chronic, terminal Mild, moderate, significant	Acute, chronic, terminal Mild, moderate, significant
Physical	NICU, hospital, foster care, residential care, child care	Home, private preschool, early childhood special education, playground or parks, Head Start, swimming pool, library	School (academic and non-academic aspects), in-home care, residential care, group home, community job site, library
Social	Family and extended family, play group, neighborhood, child care workers	Family and extended family, peers/friends, play group, teachers, classmates	Family and extended family classmates, peers/friends neighborhood, coworkers, significant other
Cultural	Family customs/beliefs/values, socioeconomic status, gender	Family customs/beliefs/values, socioeconomic status, gender, peer expectations, school rules	Family customs/beliefs/values, socioeconomic status, gender, peer culture, school rules, society rules, work opportunities and culture

Temporal Aspects

Temporal aspects include the chronological, developmental, life cycle, and disability status of the child or student. Although more emphasis seems to be on the physical aspects of the environment, temporal aspects are critical during OT service delivery.

Chronological. Chronological age should always be considered in the evaluation and intervention process; however, functional skills and age-appropriate activities rather than developmental sequence should be the guide to enhancing performance. For example, OT practitioners would assess and make recommendations for assistive technology devices on the basis of different needs among the following three children. Although all three children have difficulty using their arms for independent function, their performance needs vary within their environment because of their ages. The therapist works with the family, teacher, or child to achieve the following: Paul, age 10 months, is learning to activate musical toys by batting at them. The OT practitioner would determine the placement, size, and ease in activation of the toys. Linda, age 4½, is supported in an upright work position and uses a switch to operate a toy while she learns how to take turns with her peers. Alan, age 15, is learning to order food at a local restaurant using an assistive technology device developed by the OT and by his teacher.

Developmental. The developmental status of a child represents the level of behavioral maturation exhibited by the child at any given time. Principles of development allow the OT practitioner to place the child's observable behaviors "in context." Despite the predictable nature of development, all team members must remember that each child will develop at his or her own pace. Domains include motor, cognitive, social, language, and play skills. At any particular time, the child may give one skill area more emphasis than others. Some children remain at earlier stages of development in cognitive or motor areas while the physical development of their body continues.

Service delivery should identify the child's current developmental abilities, skills needed within the current environment, and skills needed for future environments. In the case of some children, it will be important to modify the environment or curricular aspects to improve function.

Life Cycle. Life cycle involves the phases of childhood development, from infancy to adolescence and early adulthood. Havighurst (Pratt, Florey, & Clark, 1989) has examined these phases and attributed specific tasks to each period. For example, infancy and early childhood are characterized by the tremendous learning of physical, physiological, and psychosocial tasks: to walk, talk, control bodily waste, and relate emotionally to the family. During this period, the child begins to distinguish right from wrong and to develop a conscience. Throughout the phases of a child's life cycle, learning occurs across physical and psychosocial domains.

Life is a continuous process of adaptation, in which priorities shift with the child's place in the life cycle (Mosey, 1986). When determining a child's adaptation skills, the OT practitioner should ask, "Is this task important to skills needed in later phases of the child's life cycle?"

Disability Status. Disability status refers to the acute, chronic, or terminal nature of a child's disability (AOTA, 1994). The disability status of the child not only will affect the amount of time required to complete specific tasks, but also will influence performance in all other areas. OT services may need to be increased, decreased, or discontinued, depending on the impact of the disability on performance in the current environment. The therapist should consider a child's disability status when interpreting evaluation data, formulating realistic intervention goals, and selecting appropriate methods for goal implementation.

Environmental Aspects

Intertwined with the temporal aspects is the impact of the environment on a child with disability. Environmental aspects include the physical, social, and cultural aspects of the child's environment. Occupational therapy practitioners play a special role in environmental modifications because they consider the social and cultural, as well as the physical aspects of the child's environment.

Physical Aspects. A child's physical environment may include the layout of the classroom or building, the type and arrangement of the furniture, the type of lighting or tools available, or the materials and curriculum used. The sensory impact of a physical environment on infants, toddlers, preschoolers, children, and youth is undeniably significant. For example, the hum of machines and bright lights in the NICU can be overwhelming to neonates, and large classrooms can be distracting to some toddlers or other children.

Assessing the supporting and interfering factors within the physical environment is critical to determine the relationship between context and performance and thus to plan intervention. For instance, are the bathroom facilities easily accessible and do they promote independence? What activities or equipment in a cafeteria will allow the student to be seated with same-age peers? A student who demonstrates sensory defensiveness may become extremely agitated by school bells or a fire alarm, and special modifications may be needed during these times. A child who has difficulty with unfamiliar environments or who has various health needs should receive services in an accommodating environment whenever possible.

The environments of infants, toddlers, and preschoolers must also be evaluated. For instance, bathing children with physical disabilities frequently presents problems for families and may require special modifications. The transition from one environment to another such as from home to day care, to the grocery store, or to the playground can be very difficult for some children. The different characteristics of each environment should be analyzed to ascertain possible causes of agitation. Tables 5.4 and 5.5 provide examples of this evaluation process as it relates to functional performance.

When assessing the environment, OT practitioners must observe the *natural* routine whenever possible. Whether in early intervention, preschool, or school settings, routines of timing or rhythm are visible throughout the day. In the school system the rhythm can be affected by

changes, such as a substitute teacher or a new student, which can interrupt this flow. The practitioner should seek to become a part of this flow by moving within the daily routine.

The OT practitioner must provide service within the natural timing or rhythm of the day. For example, in the school setting, how many times might a child have to put on his or her coat for recesses during the day, or how many breaks are provided for an additional snack for a child with special nutritional or feeding needs? This timing is sometimes the greatest challenge for practitioners when trying to schedule a visit to observe a student during the day. Art may be scheduled every sixth day, which requires the practitioner to schedule intervention for Monday during the first week and Tuesday the next week. Early intervention and preschool environments have the rhythm created by group times, nap times, outdoor times, or times when children need food or attention.

Social Aspects. Social needs and expectations have a great influence on skill development. The expectations of individuals significant to the child, family, or teacher can set standards for the child to achieve. For example, parents may feel pressured by grandparents to continue feeding their infant orally, even though a physician has recommended a feeding tube. Students who are integrated into general education may refuse to use any assistive devices or modifications because they want to do it "just like the other kids." Adolescents may be teased or feel isolated when they are never invited to a peer's home.

As social beings, humans need social routines and acceptance. The type and amount of acceptance needed will vary by individual. Activities to enhance the child's performance within the social environment may include modeling, teaching turn-taking during play, and allowing the child to wear clothing styles that "fit in," rather than thinking only of the ease of dressing.

Finally, social norms and role expectations are frequently set by peers or significant others. The practitioner must become familiar with these influences to better incorporate them into the therapy intervention. Creative practitioners find strategies to use these social aspects to increase motivation for both students and families. For example, a certified occupational therapy assistant (COTA) and an early childhood special education teacher developed a project where the COTA accompanied several preschoolers to the local library for story hour. At the library, the COTA facilitated proper positioning and enhanced social interactions and appropriate behaviors within the setting. Parents were excited to hear that their preschoolers could participate with other children from their community.

Cultural Aspects. Cultural values and beliefs provide the context for behavior and influence people's perceptions (Krefting & Krefting, 1991; Dunn, Brown, & McGuigan, 1994; Masagatani, 1993). Ideas about how much control individuals have over disease and illness may reflect cultural beliefs and could influence their participation and follow-through in treatment programming. For example, a parent who may be viewed as noncompliant may really believe that little can be done to change the situation. In contrast, a parent

TABLE 5.4—INDIVIDUALIZED ADAPTATION INVENTORY THAT IS ECOLOGICALLY BASED

Environment: Classroom snack time area Activity: Eating snack, drinking juice

Plan					Observation	
A Nonhandicapped Toddler Inventory	**An Inventory of Beth**	**Skills Beth Can Probably Acquire**	**Skills Beth May Not Acquire**	**Adaptation Possibilities**	**Assessment**	**Daily Plan**
Move to snack area	Cannot get to table by self	Can learn to walk		Adult can assist by using facilitation	Beth walked well when facilitation at hips was used.	Teacher will fade assistance as demonstrated by therapist. Aim for walking well with one hand held within a month.
Position self at table	Cannot get chair out to sit down	Can learn to get chair out; rotate to sit		Adult can assist with pulling chair out & facilitating rotation to sit	She pulled out chair with hand over hand; rotated & sat with facilitation from trunk.	Fade assistance in hand over hand for pulling chair; aim for pulling w/o increased tone in arms; teacher will fade facilitation for rotating to sit as demonstrated by therapist.
Take utensils when passed out	Can grasp large items					Beth will take utensils by self
Take food when passed out	Can grasp large items (cookies) but not small pieces		May not learn to grasp very small items	Try small toddler fork for small pieces or only give large finger foods.	Fork worked with "stabbable" foods.	Use toddler fork
Hold cup for liquid to be poured into	Cup is held sideways	Can learn to hold cup straight		Use cup with two handles	Beth held cup sideways with hands through handles.	Use two-handled cup.
Eat food	Can finger feed					Beth will finger feed by self.
Drink liquid	Can drink but not hold cup to mouth	Can learn to hold cup		Adult assistance to facilitate cup-to-mouth pattern	Minimal help was needed to raise cup to mouth.	Fade assistance to verbal cues "pick up cup" to no cues.
Request more if desired	Vocalizes for more		May not learn to talk	Use picture communication board during snack	A picture board with cup & correct food was used when prompted "Do you want more?" She vocalized at same time.	Teacher will make picture board each day to include cup and correct food. Place board in front of Beth and watch for her to use spontaneously. If she does not indicate that she wants more, verbally prompt. Use magnetic stove board & magnet pictures. Reinforce all joint points and vocalizations.

Baumgart, D., Brown, L., Pumpian, I., Nisbet, J., Ford, A., Sweet, M., Messina, R., & Schroeder, J. (1982). Principle of partial participation and individualized adaptations in educational programs for severely handicapped students. *The Journal of the Association for the Severely Handicapped, 7*(2), 17–27.

context

TABLE 5.5—ASSESSMENT OF ENVIRONMENT

Context Area	Expected Performance in this Context	Skills Needed (Task Analysis)	Supporting Aspects of Environment	Interfering Features of Environment	Plan (Person Responsible/Action)
Library	Students are to find and check out at least one book before returning to classroom.	Move from classroom to library.	Student independently moves to library using gait trainer.	Student takes 3 minutes longer than peers.	Allow extra time for transition, less time in library.
		Locate appropriate section of books.	Librarian is waiting by the appropriate section for class.	Student is overwhelmed by visual and auditory stimuli and needs a cue.	Librarian will verbally signal students over to appropriate location.
		Remove books from shelves.	Student can reach books only at shoulder height.	Student is unable to bend down.	Student will request help from peer helper.
		Place unwanted books on special area at end of shelf.	Student is independent if no one is in the way.	Student does not communicate intent of moving to peers and runs them over or stands and waits for them to move.	Adult will use this opportunity to model appropriate behavior.
		Take desired books to library table for checkout.	Student is independent.	Student has difficulty organizing self within time frame.	Teacher or librarian will notify class when 5 minutes of time remains.
		Hand book to librarian.	Student is independent.	N/A	N/A
		Wait quietly.		Student has sensory overload with all students at desk.	Librarian will remind all students to form a single line and not to talk.
		Receive books from librarian.	Student is independent.	N/A	N/A
		Return to classroom.	Student returns to classroom in gait trainer.	Student sees another class is coming in from recess and hears high level of noise.	Hallway monitor will remind students to be quiet and not to run.

who believes in "more [treatment] is better" may be acting on a cultural value that anything can be overcome with hard work. The OT practitioner who is sensitive to the client's beliefs about health and illness can communicate and work more effectively to help the child.

Each treatment setting has a cultural context. Cross-cultural studies of preschools (Tobin, Wu, & Davidson, 1991) show how the classroom environment and teachers' management of student behavior reflect cultural values and influence student behavior in situations such as dealing with conflict. The cultural context of schools and preschools is apparent in the way the environment is structured and in the types of activities that are presented. Class projects that are centered around holiday themes, show-and-tell activities that place emphasis on the uniqueness of each child, and the use of activity centers that encourage independent decision making and personal responsibility all reflect cultural values of the system. A child who is unable to fully participate in such activities misses out on much more than a sensorimotor or cognitive experience; through these daily activities of childhood, within the natural environment, culture is transmitted to the next generation.

Occupational therapy as a profession has a culture that reflects its core values: ideas about the meaning of disability, the importance of personal choice and independence, and the need for purposeful activity. Values may change over time and these changes may be reflected in the context of therapy. An appreciation for diversity and an individual attitude of self-reflection is necessary for the OT practitioner to provide appropriate treatment for children and their families, as well as to be comfortable and effective in the many environments in which services are provided.

Models of Service Delivery in the Environmental Context

OT service delivery is more effective when it is compatible with the profession's philosophy, reflects best practice, and smoothly integrates the various aspects of performance context. Four models of frequent environments for service delivery (home, school, community, and medical), summarized by their physical, social, and cultural characteristics, are presented next. For an ecological comparison of the four models, see Table 5.6.

The *home model* includes those natural settings in which children live, play, and learn. The family leads the decision-making process (Craig & Haggart, 1994; Fire, 1993; Turnbull, Turnbull, & Blue-Banning, 1994), and the practitioner collaborates on the family's goals. The family is seen as the primary unit whose needs greatly influence the service needs of the child. The needs of the family significantly shape the decision-making process.

The *school model* includes a natural setting in which students learn skills to prepare them for life, jobs, etc. (Benson, 1993; Giangreco, Dennis, Cloninger, Edelman, & Schattman, 1993; Vandercook & York, 1989). The practitioner collaborates with the child, the family, the teacher, and other members of the educational team. The context is created by the

TABLE 5.6—ECOLOGICAL COMPARISON OF HOME, SCHOOL, COMMUNITY, AND MEDICAL MODELS

	Home Model	School Model	Community Model	Medical Model
Physical Environment: Accessibility to and performance within	Natural settings, including home, the neighborhood, and community (i.e., day care and early intervention programs)	Least-restrictive environment where child will perform—typically the classroom	Community groups and facilities, including recreation, transportation, education, business	Hospital or clinic
Social Environment: Team makeup	Transdisciplinary team (child, family, caregivers, and service providers)	Multidisciplinary team (student, parent, administrators, teachers, related service providers, etc.)	Broadly inclusive (interested members of community)	Multidisciplinary team (child, parent, physician, and other medical personnel)
	Service coordinator varies, but is usually not the parent	Case coordinator varies, but is not child or family	Egalitarian, no head of team, any member in leadership role	Team leader is physician or case manager
Social Environment: Expectations of team	Collaborate and solve problems with family and other team members	Collaborate and solve problems within constraints of the educational program	Collaborate to increase participation	Collaborate and solve problems within defined discipline and medical program
	Train family and other caregivers such as grandparents and day care providers	Train persons in educational setting		
Social Environment: Norms, expectations, and routines of social group	Norms defined by the family culture	Norms defined by classroom rules	Norms defined by the community members	Norms defined by institution
	Wide variation in family norms	Variation in classroom norms	Diverse group of people with a common purpose for coming together	Child enters system because something is wrong
	Recognize needs of family members in addition to child's needs	Be part of the classroom to support student's full participation in school	All participate in defining problems and determining and implementing solutions	Problems defined and solutions suggested by experts
	Family dynamics include formal and informal leaders	Collaborate in problem definition; determine and implement solutions with student and classroom personnel	Define change in terms of the entire community, not in terms of an individual child	Individual therapist is accountable for outcomes
	Family and child caregivers participate in problem definition, then determine and implement solutions	Define needs and strengths using classroom skills and behaviors	All group members are accountable for creating change	Therapist holds expertise
	Define family needs and strengths	Use natural supports		Define change on basis of illness-health continuum
	Incorporate natural family events into services			

Cultural Environment: Customs, beliefs, and behavior standards	Visitor in home	Customs determined for students by school board and classroom teacher	Create outcomes where society adapts and environment allows a balance of activities for children	Decisions are made by experts, and child adapts to treatment process.
	Create outcomes in context of family and community life so child is active participant in family life	Interact with student according to classroom level, not disability		
		Create outcomes that are relevant to student's education: access to school environment, benefit from classroom learning, and learn life skills		
Cultural Environment: Political aspects and opportunities for economic support	Family and community perspective to child's needs	Educational perspective to student's needs	Funding through private sector or local governing structure	Reimbursable services determined by third-party payers or by individual receiving services
	IDEA, Part H	IDEA, Part B, Section 504, ADA	ADA	
	Interagency coordination		Social, cultural, political, environmental perspective to needs	Illness, deficit, pathology, dysfunction perspective

demands of the educational environment. OT services are directed toward supporting the child's participation in educationally related learning experiences.

The *community model* addresses the broad needs of the individual within the context of his or her community, including—yet extending beyond—the child's home and school environments (Law & Dunn, 1993). The child, family, and community define their needs and participate in designing and choosing lifestyle options. Practitioners offer expertise that can be accepted or rejected within the decision-making process (Kari & Michels, 1991). Rather than focusing on deficits by describing a child's inabilities, responsibility for meeting the child's needs is shared and defined within the context of the child's interaction with his or her environment.

The *medical model* is typically found within hospital or clinic settings (Armentrout, 1993). A physician usually determines access to services in this environment for the child and family. The physical environment tends to be less natural than those of home, school, or community models. Professionals function as experts, and their services are based on identifying and treating deficits.

PERSON-ACTIVITY-ENVIRONMENT FIT

OT practitioners working in the school system need to be aware of the methods and procedures used within that setting. Who sets the standards for the school or classroom? Who determines the classroom curriculum? What types of activities are used when a child has difficulty mastering a concept? What learning style does the child use most frequently and is it supported within the school? What is the teacher's background and experience?

The match between the child's abilities, the requirements of the activity, and the features of the environment is referred to as the person-activity-environment fit (AOTA, 1994). Variables such as novelty, importance, and motivation can enhance this fit. It is the "just right" fit that, when present, results in success. The interaction between the child's performance areas, performance components, and performance contexts is critical to deciding the outcome. Guided by the person-activity-environment fit, OT practitioners may choose evaluation methods that will provide information regarding the activity and the variables in the environment that could support or interfere with the activity, as well as determine the child's abilities.

The use of standardized tests to determine special education eligibility and programming needs is being questioned by many professionals. Even tests with good reliability and validity measures often lack usefulness in developing specific student interventions (Waterman, 1994). Occupational therapists have frequently found that standardized assessments can incorrectly identify children. Performance on a standardized test can sometimes indicate below-average skills. However, the teacher may report that in the natural or educational setting, the child is functioning with minimal or no modifications and is not displaying any signs of stress. Rather than the therapist's spending the time required

for standardized assessments, it may be more effective to use teacher interviews and to observe the child's performance within the setting.

Standardized scores are frequently used as the *standard* or comparison. Many other standards can be used within the natural environments, including local norms such as curriculum-based measurements, classroom and teacher expectations, criteria for the next environment, peer standards, and professional expectations or judgment.

Curriculum-based measurement (CBM) is based on the academic performance of students within their curriculum. CBM can be used to determine a student's strengths and weaknesses, as well as to provide information for design of instructional programs (Deno, 1985; Howell, Fox & Morehead, 1993; Fuchs & Fuchs, 1986; Fuchs & Shinn, 1989). Written communication (handwriting) standards developed through CBM can also be used by occupational therapists to assess children for difficulties with handwriting.

Classroom and teacher expectations vary. For instance, a practitioner may find the expectations different in each of the three first-grade classes in one school, but the performance within a given student's classroom sets the standard. The practitioner must be aware of that classroom and that teacher's expectations. To enhance the person-activity-environment fit, the practitioner should observe the activity, the tools used, the time of day, the seating arrangement, the motivation and attention of the student, the teacher's expectations, and the performance of the student's peers.

It is important to anticipate the needs of the child for future environments. Will there be a computer, stairs, narrow hallways, and different expectations? Sometimes the skills needed to be successful in the next environment must be addressed now. Many home-based early intervention personnel begin to prepare the toddler for preschool, while preschool teachers and related service personnel work to prepare the child for kindergarten. The transition from school to independent living may require additional goals on the IEP.

Peer standards can be easily determined and used by the OT practitioner. For example, when assessing a student's ability to put on a coat for recess, the OT practitioner can measure the "average" time it takes peers to put on coats. Or, the OT practitioner can simply have the teacher choose two or three students who are "average" and measure their time. Peer standards can provide similar measurements for the number of words written correctly in 2 minutes by second graders or the amount of time required to walk from the classroom to the bathroom.

Professional judgment provides a basis for many OT decisions. A student with limited use of an arm for handwriting would not be expected to perform within peer standards or teacher expectations, but professional judgment can establish a middle ground.

Many teachers use *ecological evaluation* of the child in the various environments as a tool for analyzing the tasks required within the child's setting and the strengths and weaknesses the child exhibits. Evaluating a child in isolation could result in

misinterpretations or inaccurate conclusions (Benner, 1992; Bronfenbrenner, 1976). Using a developmental checklist, rather than an ecological assessment, could result in inappropriate recommendations by occupational therapists. For example, various assessments and checklists state that children under age 4 should be able to cut with scissors. However, many early childhood programs do not include these skills in their curricula until the child is already close to age 4. It is important that the assessment consider what is required in the natural environment (see Tables 5.4 and 5.5). Some children may need to begin learning certain skills earlier and in isolation for use in their next environment, such as keyboarding in early elementary school for later, efficient use in junior high school.

The blend within the person-activity-environment fit can assist the therapist in providing successful matches for the child. The examples presented in Tables 5.7 and 5.8 can be used to provide therapists with information on the use of this concept.

SUMMARY

This chapter focused on the importance of assessment and application of interventions for the child or student within the performance context. In addition to environmental aspects, AOTA's "Uniform Terminology for Occupational Therapy—Third Edition" (AOTA, 1994) includes temporal aspects such as developmental level, life cycle, and disability status within its definition of performance context. This chapter provided various examples of

TABLE 5.7—SKILLS IN THE NATURAL ENVIRONMENT: TYPING

	Characteristics	Plan
Person:	Keisha is 13 and wants to learn to type. She watches her fingers because she does not seem to feel where they are. Her finger muscles are weak and poorly coordinated. Often she hits two keys instead of one. She is frustrated and types only 8 wpm.	Reassure Keisha that using her vision to substitute for the ongoing loss of sensation in her fingers is normal and necessary. Try modifications to environment.
Activity:	This typing class uses computers and a computerized keyboarding program. For students to pass, the teacher expects them to type without watching their fingers.	Don't change the activity, but meet with the teacher to discuss a new standard for passing Keisha, such as demonstrating progress in this skill. Because of her medical condition, she will continue to lose kinesthetic sensation.
Environment:	No modifications or special arrangements are currently provided for Keisha. The other 25 students in her class are able to perform this task without watching their fingers, with speed varying from 20–60 wpm.	Try a manual typewriter, which may also strengthen her fingers, or use a key guard on the computer. Find ways to motivate and support her as she develops her skills.

TABLE 5.8—SKILLS IN THE NATURAL ENVIRONMENT: USING SCISSORS

	Characteristics	Plan
Person:	Ly is 4 years old. He wants to cut with scissors during art time. He can snip the paper but has difficulty moving the paper around with his other hand to cut precisely around an object. He sometimes cries when he rips the paper.	Use the skills Ly has (snipping) to his advantage. Ly and his parents have agreed to allow modifications as needed while he is learning to use scissors.
Activity:	The preschoolers are cutting out a groundhog from an 8 1/2 x 11 sheet of construction paper. The lines are black and the sheet is a dark brown.	Provide Ly with a brown sheet of paper that is 4 x 5. Have a picture of the groundhog on the paper. Draw an oval around the groundhog and have Ly cut around this shape.
Environment:	Ly sits in a special positioning chair to hold his body upright. He rests his arms on the table and sits next to his friend, Scott, who is able to cut well. There are 5 students and 2 adults.	Use the same position. Have an adult nearby to offer encouragement. Scott can learn to give Ly encouragement, too.

ecologically based inventories to aid practitioners in assessing student needs and adaptations. Primary features in the home, school, community, and medical models were provided to allow readers to contrast aspects of each model.

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CHECKLIST OF QUESTIONS

1. Describe current methods you are using to assess performance in the natural or least-restrictive environment for children. Do these methods consider the relationship among performance context, areas, and components?
2. Describe your professional strengths and needs regarding service delivery in the natural or least-restrictive environment. Develop at least one professional goal to enhance your skills in service delivery.

Collaboration

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collaboration

Collaborating with team members and developing effective partnerships are central components of the organized framework for OT services provided under the Individuals with Disabilities Education Act (IDEA). Collaboration enables all parties who contribute to the child's success in early childhood and educational environments to coordinate their efforts and maximize their potential impact. Successful implementation of services depends on the OT practitioner's ability to develop and sustain productive working relationships with the child, members of the family, teachers, and other professionals. Components of the collaborative process include identification of mutual interests, cooperation, communication, timely sharing of perspectives and expertise, service coordination, interagency cooperation, and service integration.

DEFINITION OF TERMS

Collaboration is defined as working jointly with another person or agency. Collaboration represents a way of thinking and relating, a philosophy, a paradigm shift, an attitude change. It requires a set of behaviors, beliefs, attitudes, and values that support collective efforts.

Service coordination refers to the identification and scheduling of services authorized under IDEA's Part H, or early intervention, program. The service coordinator is the single point of contact to help parents and families obtain the necessary services and assistance that are available from several agencies (34 C.F.R. §303.6). These services are identified in the individualized family service plan (IFSP) that is developed under the early intervention program. Service coordination is synonymous with case management for children eligible under Part B of IDEA.

A *team* is defined as a number of people who work together. In early intervention and educational systems, the team consists of the child, the family, and various professionals who make up the collaborative unit. In effect, the team becomes a complex social system in which relationships, roles, responsibilities, and goals must be negotiated among the members and in which communication is essential (Minke & Scott, 1993).

A *multidisciplinary team* includes professionals from a number of different disciplines who assess and provide parallel services but who have built-in formal mechanisms for communication. For example, each team member might conduct an independent assessment of a child's development, but members might then meet for a formal case conference to share their findings and plans. The purpose of communication in this model is to ensure that team members understand the total service program package that will be undertaken. Another result of communication is that team members become aware of each discipline's contribution and understand each discipline's role.

Interdisciplinary team members make a stronger commitment to frequent collaborative communication than in the other models. Although assessments may take place as in the multidisciplinary model, the case conference is used for cooperative treatment planning. Team members collaborate to design an intervention strategy

that combines the most important treatment objectives of each discipline and maximizes the potential for a positive outcome. Interdisciplinary teams use the many unique viewpoints of team members to produce integrated plans for children and families.

Transdisciplinary team members make a commitment to cross traditional disciplinary boundaries by teaching and learning from others. Assessment, treatment planning, and service provision are often conducted simultaneously by more than one discipline. Areas of overlap among disciplines are frequently used as the springboard for other shared activities. Allocations of duties are based on actual, rather than disciplinary, expertise (AOTA, 1989).

A *role* is defined as an expected pattern of behavior that is determined by an individual's position or function within a particular society. Within a team, each team member has a unique role, and sometimes members have overlapping roles. These instances require good communication and interaction to determine the appropriate service provider to meet the child's or family's needs.

Mentoring involves acting as a trusted counselor or guide to another individual and implies an interactive relationship to provide professional growth and support. This type of relationship can occur between individuals of the same profession or among team members of differing professions.

Supervision, in contrast to mentoring, is defined as critical watching and directing of activities and implies a more hierarchical relationship. The *Guide for Supervision of Occupational Therapy Personnel* (AOTA, 1994) describes supervision as a "mutual undertaking that fosters growth and development," and in this sense, it is collaborative.

LEGISLATIVE CONSIDERATIONS

Recent special education and health legislation has moved families (the consumers) to the forefront by focusing on their needs in programming decisions and by ensuring their rights to services and due process (Gallagher, Trohanis, Clifford, 1989; Trohanis, 1989). Beginning in 1987 with Surgeon General C. Everett Koop's report on children with special health care needs, a number of laws (for example, the Katie Beckett Program, 42 §1902[e] of the Social Security Act; the Individuals with Disabilities Education Act; the Developmental Disabilities Assistance and Bill of Rights Act; and the Mental Health Amendments of 1990) have provided mandates for family-centered, home, or community-based coordinated service systems (Ahmann, 1994). These laws emphasized that service delivery for children with disabilities should be collaborative.

Coordination of services and interagency coordination is mandated in IDEA, particularly within Part H, the early intervention programs. The lead agency for Part H services is responsible for entering into formal interagency agreements with other state-level agencies involved in the state's early intervention program. Each agreement must meet the following requirements:

- define financial responsibility of the agency paying for early intervention services

- include procedures for achieving timely resolutions of interagency and intra-agency disputes about payment for matters related to the early intervention program, including payment for services
- include any additional components necessary for effective cooperation and coordination among all agencies involved in the statewide early intervention system (34 C.F.R. §523).

Under IDEA, each team determines a service coordinator whose role is identified under the law (see Table 6.1A).

TABLE 6.1A—REQUIRED SERVICES AND TEAM MODELS UNDER IDEA

Part H

Early intervention services are designed to

- meet the developmental needs of the child and family related to the child's development
- meet state standards and are provided under public supervision by qualified personnel.

Services include

- family training, counseling, and home visits
- special instruction
- speech pathology
- audiology
- occupational therapy
- physical therapy
- psychological services
- service coordination
- medical services only for diagnostic or evaluation purposes
- early identification, screening, and assessment services
- health services
- social work services
- vision services
- nursing
- nutrition services
- assistive technology devices and services
- transportation and related costs necessary to receive early intervention services.

Part B

Free appropriate public education (FAPE) are services meeting state standards and are provided under public supervision by qualified personnel.

Services include

- special education (specially designed instruction) to meet the unique educational needs of the child including classroom instruction, instruction in physical education, home instruction, instruction in hospitals and institutions, vocational education (if specially designed)
- related services needed by the child to benefit from special education
- transportation, developmental, corrective, and other supportive services including
  - speech pathology and audiology
  - psychological services
  - physical and occupational therapy
  - recreation
  - social work services
  - counseling services
  - medical services (diagnostic and evaluation only)
  - parent training and counseling
  - assistive technology devices and services
  - rehabilitation counseling
  - school health services.

TABLE 6.1A (CONTINUED)

Part H	Part B
Multidisciplinary with family-centered focus specific to the developmental needs of the child.	Multidisciplinary with student-centered focus specific to the student's educational/learning needs.

TABLE 6.1B—INDIVIDUALIZED PLAN REQUIREMENTS UNDER IDEA

Part H

Individualized Family Service Plan (IFSP)

IFSP components emphasize a family-centered approach addressing the developmental needs of children and families.

Service coordinator facilitates written plan for providing early intervention to child and family as soon as possible after the IFSP meeting. With parent consent, services may begin before evaluation and assessment are complete via an interim IFSP.

Must include

- statement of present levels of physical, cognitive, communication, social or emotional, and adaptive development based on acceptable objective criteria.
- family information, with their agreement, on resources, priorities, and concerns related to the child's development.
- statement of major outcomes expected for the child and family with criteria, procedures, and time lines used to determine progress and changes needed.
- statement of specific early intervention services necessary, including frequency, intensity, and method of delivering services.
- statement of natural environments in which early intervention services shall appropriately be provided.

Part B

Individualized Education Program (IEP)

IEP components emphasize meeting the student's educational needs through services, which the school must ensure are available.

Written plan must be in effect at the beginning of each school year and before any special education and related services are provided. It should be implemented as soon as possible after the IEP meeting.

Must include

- statement of the present level of educational performance.
- annual goals, including short-term instructional objectives.
- specific special education and related services to be provided, and the extent that the child will be able to participate in regular education programs.
- statement of the needed transition services for students beginning no later than age 16 and annually thereafter (begin at age 14 or younger when appropriate). Plan should include, when appropriate, a statement of interagency responsibilities of linkages before student leaves school setting.

TABLE 6.1B (CONTINUED)

Part H	Part B
• dates for initiation of services and the anticipated duration of each service. • name of the service coordinator responsible for IFSP implementation and coordination. • transition plan for the toddler's exit from Part H into Part B or other services, as appropriate.	• projected date for initiation and anticipated duration of services. • appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether instructional objectives are being achieved.

TABLE 6.1C—REQUIRED TEAM MEETING PARTICIPANTS UNDER IDEA

Part H	Part B
Parents or guardians, family members, service coordinator, and other specialists, as needed.	Student's teacher, representative of the local education agency (LEA) who can provide and supervise the provision of special education, parents or guardian, other individuals at parent's or agency's discretion, and the child (if appropriate).

Parent participation and rights and grievance procedures have also been outlined within IDEA. IDEA requires a parent's written consent only when the child is being identified, evaluated, or placed. Changes in placement, such as discontinuation, or increase or decrease in services, require written notification by the service coordinator. Parents may file a complaint if they disagree with the changes (specific procedures may vary from state to state.) Best practice would suggest that ongoing communication exists between the parents, the educators, and the child. Therefore, any changes would have been discussed with parents prior to written notification (see Table 6.2).

COMPONENTS OF COLLABORATION

Collaborative teaming must contain certain critical components:

- a mutual agreement on at least one common goal
- a belief system that respects the special expertise of all team members
- parity in the valuing of each member's input

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TABLE 6.2—PARENTAL RIGHTS UNDER IDEA

Part H	Part B
Written prior notice must be given whenever state agency or service provider proposes to initiate or change, or refuses to initiate or change identification, evaluation, placement, or provision of appropriate early intervention services.	Written prior notice must be given whenever proposing to initiate or change, or refusing to initiate or change, the identification, evaluation, or educational placement.
Notice must fully inform in the native language.	Notice must fully inform in the native language.
Parental consent is required for initial evaluation and release of information. Parent(s) has right to accept or decline any early intervention service.	Parental consent is required for initial evaluation and placement in special education and related services. Consent may be withdrawn at any time. Consent for release of information is required.
Parental rights provisions also include · right to confidentiality per the Family Educational Rights and Privacy Act (FERPA), and confidentiality requirements established in IDEA, Part B. · right to inspect and review child's records. Parent(s) can request amendments to the record; a hearing process is prescribed if the agency/local service provider disagree. · timely administrative resolution of individual child complaints by the parent. · protection of child's rights when parents/guardian unknown or child is ward of state.	Parent(s) has the right to inspect and review child's records (FERPA and confidentiality requirements established in Part B apply). Parent(s) can request amendments to the record; a hearing process is prescribed if agency/local service provider disagrees. Procedures are in place to protect the rights of the child whenever parent/guardian is unknown or child is ward of the state.
During pendency of any proceeding or action involving a complaint, child must continue to receive services currently being provided unless parent and agency otherwise agree.	Parent or agency may initiate an impartial due process hearing on any matter related to when an agency proposes or refuses to initiate or change the identification, evaluation, or educational placement of child, or provision of FAPE. During pendency of any judicial or administrative proceeding regarding a complaint, child must remain in present educational placement unless parent and agency otherwise agree. This "stay-put" provision is modified by the Gun-Free Schools Act of 1994 if the student brings a firearm to school and the behavior is not related to their disability.

- leadership distributed among group members
- engagement in team behavior that "involves face-to-face interaction; positive interdependence; the performance, monitoring, and processing of interpersonal skills; and individual accountability" (Thousand & Villa, 1992, p. 76).

The interactive process inherent in collaborative teaming is likely to yield more comprehensive, creative, and effective solutions than those generated individually by team members (Idol, Paolucci-Whitcomb, & Nevin, 1986).

Productive Teaming

Teaming may be defined as "professional and parental sharing of information and expertise" where two or more individuals work together to meet a common goal (Morsink, Chase Thomas, & Correa, 1991). Early intervention and school-based practitioners are bound to team ownership of the child's developmental and educational needs as determined by professionals and the family. The IFSP or IEP created for the child are integrative products of a team approach in which the family's needs or the child's educational program needs are the central focus of service delivery. Giangreco (1986) suggests the quasi team (in which interdisciplinary team members meet to discuss the individual but agree to pursue their own separate, discipline-referenced goals) is not the intended multidisciplinary process outlined in IDEA. Not just any service is necessarily appropriate service delivery (Strain, 1990). Productive teaming may require the following:

- breaking boundaries between professions, recognizing overlapping areas of expertise, and selecting the best provider or providers for the child's or family's program
- participating in role release, including sharing of professional competencies with other team members to facilitate multiple practice experiences in natural environments
- selecting team members' roles and responsibilities on the basis of service gaps and overlapping areas of practice in service to the child and family
- shifting the thinking about acceptable modes of operation in order to implement innovative methods on the basis of individualized needs of the child and family
- communicating and interacting by using mutually understood vocabularies and procedures (Dunn, 1991; File & Kontos, 1992).

Some practitioners have found that professional identity and self-esteem are at risk in entering into such a complex and still ambiguous team process (Lawlor & Cada, 1993; Lawlor & Mattingly, 1995; Sears, 1981). Some of the issues in teaming may include determining which professional competencies may be effectively or safely shared with other team members, especially if they lack a similar knowledge base (Dunn, 1991); solving logistic problems such as sufficient and common times and locations for meetings and program implementation; having adequate personnel staffing in education and related services; obtaining reimbursement for alternative

modes of service delivery; and overcoming the lack of training in conflict resolution and teaming process negotiation.

Because it is based on shared responsibility for the family service or education plan (IFSP or IEP), collaboration is the dynamic, overarching process through which quality interventions are designed, implemented, modified, and evaluated. Current educational initiatives such as full inclusion have influenced best practice in the selection and placement of interventions in early intervention and school systems requiring integrated teams (Dunn & Westman, 1995). These two educational initiatives focus on successful placement and support of children in natural, mainstream community settings. Given the special needs of children with disabilities and their families, these objectives are best achieved using the team's collective knowledge and skills.

The service delivery continuum for OT practitioners and other team members is determined by team-developed goals (as outlined in the IFSP and IEP) that meet the need for both collaboration with other team members and intervention with the family or child to gain appropriate educational programming. To develop the intervention plan for a family or student, the team would typically proceed through the following steps:

1. A team leader is selected to notify team members of meeting times, places, and information to be read before the meeting.
2. The leader introduces all team members and frames the purpose and agenda of the meeting.
3. The group works to achieve a consensus on a specific, measurable definition of problems and available assets.
4. The group sets priorities of importance among the identified needs and desired performances.
5. The team discusses the history and frequency of the identified problems and previous intervention strategies.
6. Team members brainstorm possible interventions and reach a consensus on the interventions to be used and on which team members are responsible for implementation.
7. Team members determine evaluation procedures and time lines.
8. All team members' responsibilities are clarified regarding implementation, provision of materials, consultation, collaboration, service delivery site, and use of strategies and time lines.
9. At the predetermined time, or earlier if needed, team members return to evaluate the plan or program's effectiveness and needed changes (Morsink, Chase Thomas, & Correa, 1991).

Roles in Program Planning

In early intervention, a multidisciplinary team of professionals collaborates with the parents to identify needs for service delivery, to identify a service coordinator who is responsible for implementing the IFSP, to consult with the parents and each other to ensure effective service delivery, and to train parents and others regarding service. Recent early intervention laws place a greater emphasis on parent participation,

coordinated case management, and integrated multidisciplinary services.

In school-based practice, some latitude exists in deciding who will attend the meeting to develop the student's individualized education program (IEP). Schools must take a number of steps to ensure that the parents of the child with disabilities are present or are given the opportunity to participate through other means. The team itself may be composed of the child's parents; the teacher; a representative of the school; the child (required after 16 years of age); other individuals invited at the discretion of the school or the parent (this group may include related service professionals or parent advocates); and, in cases of transition, a representative of the next service agency. Not all team members who provide services to the child are required participants at the IEP meeting; however, those present are charged with determining the child's need for educational and related services. The IEP's requirements for the school-age child are less directive in requiring collaborative, coordinated, and multidisciplinary practices. Still, collaboration is vital to constructing IEPs that meet the needs of students with special learning needs (see Table 6.1C).

For all children participating in IDEA, the law emphasizes that they remain within the mainstream of their own communities rather than in isolated settings. The requirements for community and least-restrictive environmental contexts result in additional opportunities for collaboration. Since service delivery sites in early intervention may be the home, frequent family or professional contacts provide opportunities for collaborative strategies to enhance the development of children with special needs. For school-age children and their families, placement close to the home allows families to have reasonable access to participate in their child's education and allows children to develop relationships in school that strengthen ties to their community.

Family Roles

Early intervention services provided through Part H of IDEA may be a family's first introduction to service delivery. The service delivery process provides opportunities for parents to participate and specifies parental responsibilities that include the following:

- assessing supports and services needed for the family
- identifying family priorities and concerns
- determining resources
- participating in development of the individualized family service plan (IFSP)
- consenting to the provision of early intervention services.

Occupational therapy practitioners and other team members must ensure that parents are included in the team process. The team should assess the extent to which they involve parents and articulate a collective philosophy about parent and professional collaboration. Table 6.3 provides a summary of principles developed by the Association for the Care of Children's Health. Table 6.4 shows the roles mandated by IDEA.

TABLE 6.3—PRINCIPLES OF FAMILY AND PROFESSIONAL COLLABORATION

1 Promote a relationship in which family members and professionals work together to ensure the best services for the child and the family.

2 Recognize and respect the knowledge, skills, and experience that families and professionals bring to the relationship.

3 Acknowledge that the development of trust is an integral part of collaborative relationships.

4 Facilitate open communication so that families and professionals feel free to express themselves.

5 Create an atmosphere in which the cultural traditions, values, and diversity of families are acknowledged and honored.

6 Recognize that negotiation is essential in a collaborative relationship.

7 Bring to the relationship the mutual commitment of families, professionals, and communities to meet the needs of children with special health needs and their families.

Source: Shelton, T. L., Jeppson, E. S., & Johnson, B. H. (1992).

TABLE 6.4—PROFESSIONAL AND FAMILY ROLES UNDER IDEA

	Part H	Part B
Professional Roles	Service provider	Service provider
	Team member	Team member
	Service coordinator	Case manager
Family Roles	Parent	Parent
	Team member	Team member
	Child's advocate	Child's advocate
	Service coordinator	

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Active and informed parental participation is vital to developing the IFSP, which is the basis for service delivery in early intervention. Parents may agree or disagree with the recommendations of professionals on the multidisciplinary team; only those services to which they consent are provided. The IFSP may list services that the family needs but that are not covered under service delivery, such as medical or respite services. The service coordinator is then charged with assisting the family in obtaining those services.

Likewise, once the child enters the school system, parents are expected to participate in developing the child's IEP as full members of the multidisciplinary team. Procedural safeguards provide that parents have the opportunity to examine all relevant records for their child, that they be notified of any proposed program changes, and that they have access to due process to appeal educational placements or IEP decisions. The IEP is legally binding and documents the requirement that the school provide those services described, at no cost to the family and in a timely manner (see Table 6.1B).

COLLABORATIVE PROCESS IN SERVICE DELIVERY

Collaboration with Other Service Providers

Traditionally, OT services have been separated into categories of services, such as direct, consultative, and monitoring. Frequently, the occupational therapist was solely responsible for determining which level of services a child required, from direct services to monitoring. However, in current early intervention and school-based programs, these categorical, linear distinctions are less helpful since they fail to recognize a collaborative team approach to service delivery. OT services may be delivered in many different forms that vary according to the focus of services, the individuals who participate, the competencies of other team members, and the delivery sites.

For example, in a preschool program where both the teacher and the occupational therapist are skilled at facilitating children's fine motor skills, the occupational therapist may use a multipronged approach in delivering services, such as the following:

- mutually determining, through discussion with the teacher, the best plan for integrating therapeutic interventions in the classroom
- sharing knowledge with the teacher regarding the child's specific difficulties of in-hand manipulation and how those difficulties affect the child's participation in the curriculum
- providing adapted scissors or pencil grips for use in the classroom during fine motor activities.

The discussion with the teacher could address

- what the teacher's priorities are for developing the essential skills that will allow the child to participate fully in the classroom
- whether training of other team members is appropriate and would assist in integrating this intervention across school environments

- what classroom routines currently address these needs
- whether additional opportunities for practicing manipulation skills need to be incorporated
- how the curriculum might reasonably be altered to accommodate the child's needs and provide increased practice opportunities of those specific skills
- what additional toys or materials could be made available to the child to foster development of manipulation skills.

According to this hypothetical discussion, the teacher and therapist might decide that the configuration of service delivery should include the following:

- weekly planning and evaluation sessions to address curriculum adaptations and assess the child's progress
- training sessions of 15 minutes, with the classroom aide demonstrating the appropriate technique for using the adaptive equipment (scissors and pencil grip)
- activities for developing manipulation skills
- hands-on intervention sessions with the student during a 30-minute free-play period to develop postural mechanisms, wrist stability, and manipulation skills.

This multipronged configuration of service delivery uses a fluid, collaborative process that may change as the child progresses and as other conditions warrant. As the teacher and teaching assistant become increasingly skilled at implementing therapeutic activities, the occupational therapist may decrease the frequency of planning and training sessions and may focus more on working directly with the student. Conversely, the therapist may increase planning and training sessions to increase the number of therapeutic activities incorporated into the daily schedule and may decrease the time spent in hands-on intervention with the child.

No one service delivery method is exclusively better than another. Direct service delivery is the role in which occupational therapy practitioners have most commonly been engaged. Teachers and parents may feel that only direct services are acceptable (Hanft & Striffler, 1995), although consultative services have proven equally effective for some students and have increased teachers' appreciation of OT's contributions to education (Dunn, 1990). Consultation means sharing of expert knowledge by one team member with another or other team members. The role of consultant may shift among team members depending on the currently identified problem. Rather than being in an authoritarian position, consultation reflects the collegial nature of the team.

Cooperative interventions may be designed by several team members and may be included in the child's programming in one or more natural settings. In such cases, several team members may mutually determine the program strategies and then use the same strategies in all of their contacts with the child or family across all settings. Goals involving language, augmentative communication, positioning for function, or behavior often require this kind of team cooperation in

planning and implementation. For instance, the student who is learning to use a communication device to develop effective communication needs to understand the importance of communication in all social environments. If the child uses an augmentative communication board to make choices only during an individual speech session, but never uses it during meal time to select menu choices or during play to signal choices of activities, the efficacy of this communication intervention is undermined.

Research has shown that interventions that are set in natural environments and embedded in class routines that use functional life skills increase the efficacy of intervention, the achievement of IEP goals, and the motivation to participate (Dunn & Westman, 1995; Dunn, 1991; Giangreco, 1986). This research has provided an impetus to move from *isolated* therapy provision to *integrated* therapy services. Along with this shift come changes in (1) the site of service delivery, from the therapy room to the community site or school campus; (2) the focus of therapy outcomes, from improving postural and balance responses to improving sitting during dining; and (3) the personnel involved, from only the practitioner and child, to several team members and the child. By bringing the interventions into the classroom, lunchroom, gym, and home or community site, integrated services increase the opportunities for collaboration and skill building among team members, along with practice opportunities for the student or young child.

Integrated and cooperative interventions in education and therapy provide essential practice opportunities for students with severe disabilities and enhance the effectiveness of therapy (Campbell, McInerney, & Cooper, 1984; Dunn, 1991; Sternat, Messina, Nietupski, Lyon, & Brown, 1977). It is important to recognize when deciding on service delivery that the IFSP or IEP determines team configurations but not the method of delivery.

Alternative service delivery methods require that OT practitioners not accustomed to or trained in these collaborative and integrated methods acquire new skills (File & Kontos, 1992). Collaborative, consultative, and cooperative interventions demand effective interpersonal, and negotiation conflict resolution skills. Practitioners need the following:

- personal flexibility and mastery of increasingly complex practice settings (Sears, 1981)
- knowledge of community resources, available educational programs and placements, and school structure and administration
- familiarity with case management, other discipline's expertise, and team members' personal styles.

In addition, practitioners must learn to think about service delivery in new and different ways.

Collaboration Between the OTR and COTA

In early intervention and school system practice, as in other areas of OT practice, the registered occupational therapist (OTR) has the ultimate responsibility for

service delivery. Included in this responsibility is the supervision of the activities performed by the certified occupational therapy assistant (COTA). In the AOTA (1994) document, "Guide for Supervision of Occupational Therapy Personnel," supervision "fosters growth and development; assures appropriate utilization of training and potential; encourages creativity and innovation; and provides guidance, support, encouragement, and respect while working toward a goal." This document also notes that "the amount of supervision required varies, depending upon the OT practitioner's clinical experience, responsibilities, and level of expertise." Levels of supervision should be determined by the OTR according to the service needs within a given program setting. However, AOTA states that COTAs, at all levels of practice, require at least general supervision by an OTR. General supervision requires at least monthly direct contact, with supervision available as needed by other methods (AOTA, 1994). Supervision requirements may also be defined in state OT practice regulations, which take precedence over all other standards of practice.

The COTA must demonstrate service competencies before supervision standards can be determined. Supervision may involve record review, observations of service delivery, informal or formal meetings, or shared intervention. Service competency can be established by determining whether two people can perform the same procedure and obtain the same result. When an OTR delegates an evaluation or intervention task to the COTA, there must be a high degree of confidence that the COTA will perform the task the same way that an OTR would have performed it—and will obtain the same information. Service competency is critical in the collaborative relationship between the OTR and the COTA because the OTR is legally responsible for the outcomes of all OT services. When a high degree of confidence cannot be ensured, the OTR must question the appropriateness of delegating that task.

Service competency in intervention can be established through cooperative intervention. The OTR can observe the COTA's performance and the decisions that are made as the intervention session progresses, thereby determining whether the same process would have occurred had the OTR been providing the intervention. Service competency can be more easily established for frequently used procedures, whereas infrequent procedures may require closer supervision.

The roles of the OTR and the COTA complement each other and contribute to a more comprehensive program of OT services. Chapter 7, "Outcomes," outlines service delivery roles for the OTR and the COTA in both early intervention and school system settings.

Collaboration Between the OT Practitioner and the OT/OTA Student

Early intervention and school system settings have emerged as two of the largest practice settings for OT practitioners, resulting in increased opportunities for OT practitioners. However, more fieldwork sites need to be available to adequately prepare OT practitioners for these areas of practice. Practitioners working in these

settings must make a professional commitment to share the responsibility for the clinical education and training of future practitioners.

Collaborating with an OT or an OTA student includes significant supervisory and mentoring responsibilities. The OTR or the COTA who provides fieldwork experience must have the skills required to supervise students and the administrative support necessary to accomplish this activity. Sometimes the complexities of the day-to-day duties associated with OT service delivery make it difficult for the OT practitioner to consider taking on the responsibility of a student's clinical education. However, in many cases, the personnel within early intervention programs and school systems recognize that students are potential employees who may return to fill positions that might otherwise remain vacant or be filled by personnel who are not adequately trained.

In accepting responsibility for the supervision and education of an OT or OTA student, the OT practitioner enters a collaborative relationship with the academic institution or the training program attended by the OT or OTA student. This relationship is usually formalized by a written contract between the OT practitioner and the student's university or technical college program, or between the OT practitioner and the individual OT or OTA student. In addition, the OT or OTA student may sign a contract that would describe specific learning objectives and learning activities to be accomplished during the fieldwork experience.

The "Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapist" (AOTA, 1991a) and the "Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapy Assistant" (AOTA, 1991b) direct educators to include information about various practice settings (Amundson, 1995), including early intervention and school systems. In addition, "Guidelines for Curriculum Content in Pediatrics" (AOTA, 1991c) steers academicians to the essential minimal pediatric content. It also includes early intervention and school-based practice that is suggested for entry-level practice (Amundson, 1995). These guidelines would help the OT practitioner to recognize what the educational background is for the OT or OTA student. In addition, manuals are available that provide a framework for fieldwork experiences in school-based and early intervention settings. Two such manuals are *Occupational Therapy Fieldwork II Training Manual: School-Based Practice in Rural Settings* (Amundson, 1994) and *OT: Early Intervention Preservice Training Program* (Hinojosa & Anderson, 1989).

While supervising an OT or OTA student involves taking responsibility for the professional development of a future OT practitioner, it also provides an opportunity to establish another collaborative relationship or partnership that will eventually enhance the delivery of OT services to children and families.

SUMMARY

Collaboration is not a simple process, but with the mutual sharing of information, parents and team members can create innovative solutions. Collaborative OT

practice may require professionals to shift their methods of practice and practitioners and parents to develop new skills and abilities. All those engaged must participate in an arena that is not as yet clearly defined. As effective collaborators, professionals accept blending roles, sharing expertise with other professionals, participating in role release for the benefit of the student, becoming comfortable with new roles, tolerating ambiguity in professional roles, and sharing mutually generated vocabulary, roles, and procedures. Both families and professionals need to invest in the development of relationships and promote interactions that support family-centered practices. Collaboration is aimed at developing best practices in the interests of children and families, and it will continue to be a challenge to all professionals and families participating in early intervention or special education.

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CHECKLIST OF QUESTIONS

1. Consider the different teams with which you collaborate. Which ones seem most effective? Can you list specific strategies that the team(s) uses to be successful?
2. Which teams are not effective? List three things you feel are interfering with their effectiveness. Can you devise strategies to minimize this interference?
3. Describe how an OT practitioner might use role release to collaborate with another service provider.

Outcomes

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Occupational therapy practitioners who work under provisions of the Individuals with Disabilities Education Act (IDEA) need to be very aware of the outcomes of OT services. In an era of decreasing resources, payers of services, including taxpayers, are increasingly interested in the outcomes, or results, of the services. Much has been written recently about the outcomes of public school education. Is the educational process yielding the informed, thinking citizen (and worker) so valued in American society? Are the efforts and expenditures of special education yielding the equal opportunities they are designed to provide? The results are inherently intertwined with the context in which they are achieved. Outcomes are not the sole aim of intervention but may be thought of as what occurs throughout the intervention. As such, outcomes must be thought of as part of a dynamic process as well as a product of OT services.

This chapter is divided into two sections: Service Delivery: Student-Specific Outcomes and Program-Specific Outcomes. The first section discusses procedures and activities specific to service delivery, including referral and screening, evaluation and assessment, and development of the Individualized Education Program or Individualized Family Service Plan.

It also provides specific intervention information about the service continuum, ongoing evaluation, data collection, and discontinuation of services. The second section discusses methods to determine and evaluate the effectiveness of services.

DEFINITION OF TERMS

An *outcome* is the result of some event or action. Outcomes, as defined in Part H of IDEA, are statements of the changes that families would like to see for their child or themselves in relation to the identified developments or needs. Outcomes are to be prioritized by the team and written on the IFSP document in the language used by the family.

A *goal* is the desired behavior to be brought about by the services. In Part B of IDEA, a goal is a statement of projected behavior change that will occur over a 1-year period. The "Standards of Practice for Occupational Therapy" (AOTA, 1994a) states that goals are to be clear, measurable, behavioral, functional, and appropriate to the individual's needs.

An *objective* is the projected behavior that would indicate progress toward an annual goal. Objectives should represent specific, measurable, intermediate steps. A statement of the objectives describes the child's performance, the conditions under which the performance is to occur, and the criteria for the acceptable level of performance.

An *OT intervention plan* guides the direction of OT services and defines the responsibilities for achieving the expected outcomes. The plan is similar to the treatment plan used in other OT practice settings. The OT intervention plan is an important document that describes the special contribution OT makes to the child's educational program.

Program evaluation involves determining the effectiveness of OT services, is based on

the individual needs of the student or child and can be conducted both qualitatively and quantitatively.

LEGISLATIVE CONSIDERATIONS

Federal regulations mandate that the local education agency (LEA) must identify, locate, and evaluate all children in their jurisdiction who have disabilities and need special education and related services. The LEA may make a referral for OT services when a child demonstrates dysfunction in the performance areas of self-help or adaptive skills, work, and productive activities; in play or leisure activities; and in the performance components of sensorimotor, cognitive, and psychosocial development that may affect the learning process (AOTA, 1994b).

Part H and Part B of IDEA contain requirements about evaluation and assessments to identify appropriate services. Key points are listed in Table 7.1. The focus of Part H is the multidisciplinary assessment that focuses on the unique strengths and needs of the child, as well as the family resources, priorities, and concerns. Part B emphasizes the multidisciplinary team's role in determining eligibility for special education resources and what support is necessary for students to benefit from educational (academic and nonacademic) programs.

SERVICE DELIVERY: STUDENT-SPECIFIC OUTCOMES

The IEP uses the term *goal* for anticipated behavior change, while the IFSP uses the term *outcome* for the statement of the desired change. In this section, the word *outcome* will be used in a broader sense that incorporates both of these terms and addresses the effects or results of service delivery.

Referral and Screening

The referral process in school-based and early intervention practice covers multiple outcomes. At a minimum, the referral is documented and should include the following:

- documentation of source of referral
- attainment of parental permission for screening or evaluation
- review of available information to determine if referral is appropriate
- completion of screening after determining the specific reason for referral
- determination of whether intervention or further testing is necessary and identification of dysfunction in performance areas
- report to the school-based team and referral source about the results of screening and the need for further evaluation
- referral of students to other appropriate resources when knowledge and expertise of other professionals is indicated.

Some states and agencies, as they determine eligibility for special education or early intervention services, use prereferral or problem-solving strategies before making a formal referral. These activities may include providing or modifying equipment, providing strategies to the teacher to enhance student performance, and provid-

Part H	Part B
Must include timely, comprehensive, multidisciplinary evaluation for each child referred for evaluation, including assessment activities related to the child and family.	Tests and other evaluation materials are provided and administered in the child's native language or mode of communication and are nondiscriminatory.
Evaluation must be conducted by personnel trained in appropriate methods and procedures, be based on informed clinical opinion, and include • review of pertinent records related to the child's current health status and medical history • evaluation of the child's level of functioning in each of the five developmental domains • assessment of the unique needs of the child in terms of each of the developmental areas, including identification of services appropriate to meet those needs.	Materials and procedures are administered by trained personnel in conformance with the instructions provided by their producer, are validated for the specific purpose for which they are used, assess the specific areas of educational need. No one procedure shall be the sole criterion for determining an appropriate educational program.
A family-directed assessment (with any assessment voluntary on part of the family) to determine family resources, priorities and concerns related to enhancing the child's development. It must be based on information provided by the family through personal interview and incorporate family's description of resources, priorities, and concerns related to enhancing the child's development.	Evaluation must be made by a multi-disciplinary team, including at least one teacher or specialist with knowledge about the suspected disability. The child is assessed in all areas related to the suspected disability.
IFSP shall be developed within a reasonable amount of time after the assessment is completed. Early intervention services may begin prior to the completion of the evaluation and assessment, if parents consent and an interim IFSP is developed.	Placement is based on information from a variety of sources, documenting and considering all data sources. Decisions are made by a group of persons, including persons knowledgeable about the child, the meaning of the evaluation data, and the placement options. An IEP must be developed if the child needs special education and related services. Reevaluation is conducted every 3 years, or more frequently if conditions warrant, or if the child's parent or teacher requests an evaluation. Parents have the right to get an independent educational evaluation, which must be considered by the agency related to FAPE or by a hearing, which may be at public expense if requested by a hearing officer or if the parent disagrees with agency evaluation (which the agency can contest through a hearing).

ing interventions to the student in the area of concern. The purpose of prereferral is to support the student's learning in his or her natural, or least-restrictive, environment. For some students, more intensive services are needed (Clark & Miller, 1996).

A physician's referral should be obtained when state practice laws, agency policies, or professional judgment require it. The referral should be in writing. Some state education agencies require that local education agencies (LEAs) use a standard form for physicians' referrals. The following information should be contained on the physician's referral:

- child's name, date of birth, diagnosis
- date of referral
- parent or guardian name, address, and telephone number
- address and telephone number of the physician
- recommendation for an OT evaluation and/or intervention
- precautions or contraindications for evaluation and/or intervention.

For a flowchart of OT service delivery, see Table 7.2.

Evaluation

The evaluation process in educational and early intervention environments is critical to the outcomes that eventually occur. The composition of the multidisciplinary team is determined by the referring problem, by prior attempts to remediate, and by agency procedures. From an occupational therapy perspective, the evaluation should do the following:

- be conducted with parental permission
- assess the child's performance areas, performance components, and performance contexts
- use methods appropriate to the child's age and developmental level; gender; and socioeconomic, cultural, and ethnic background
- use the child's native language
- include the following evaluation methods:
  - observe the child in the multiple environments in which he or she is expected to function
  - interview the child or student (as appropriate), teacher, parents, and other significant individuals
  - review records, student portfolio, report cards, samples of student's work, and other relevant documentation
  - assess educational requirements and student performance to determine the significance of the discrepancy (school age) or assess the developmental skills and family needs (early intervention)
- document results within the established time frames
- communicate the purpose, procedures, and results of OT evaluation within the boundaries of client confidentiality to the appropriate persons.

OT practitioners working in early intervention, preschool, and school settings should use AOTA's "Uniform Terminology for Occupational Therapy—Third Edition"

TABLE 7.2—FLOWCHART FOR OT SERVICE DELIVERY

Step 1	Identify problems (develop specific evaluation questions).
Step 2	Select measurement strategies to collect baseline data (screening, observation, interview, or assessment).
Step 3	Determine present level of functioning (screening, observation, interview, or assessment).
Step 4	Compare to expected level of functioning (screening, observation, interview, or assessment).
Step 5	Complete written documentation of evaluation results and recommendations regarding OT services.
Step 6	Participate in staffing to determine eligibility for early intervention and special education and/or need for OT services. (Is performance discrepancy large enough that it results in a significant delay or educational disadvantage?)
Step 7	If child is eligible, team develops individualized plan (IFSP or IEP): Outcomes (Part H) or Goals and Objectives (Part B).
Step 8	OT develops intervention plan for own use.
Step 9	Evaluate intervention for effectiveness. Use data to recommend changes in service as appropriate. Plan for discharge when appropriate.

(AOTA, 1994b) as a guide for evaluation. The evaluation will involve examining the interactive relationship between a child's performance areas, performance components, and performance contexts. Relevant roles and functions of the child should be based on the setting, age, and program demands.

The evaluation process for OT practitioners working in school and early intervention settings offers many unique opportunities. Because the therapist is able to observe the child functioning in his or her natural environment and to observe products of the child's performance (the child's written work, amount of lunch eaten, pulling self into standing position at the couch), reliance on criterion-referenced (standardized) tools has declined in favor of functional assessments. When therapists use functional assessment tools, the procedures depend on the questions asked or the decisions to be made. Therapists must immediately define the problem, collect baseline data related to the problem, determine the expected performance, and decide if a significant discrepancy exists.

By collecting information within the natural setting, rather than by pulling the child out to be tested, the OT practitioner provides a more natural approach to evaluation, intervention, and programming

needs. This approach assists in program termination because it allows the therapist to compare the child's performance with the prevalent classroom or developmental standards (judgments by teacher, peer, district, or families) and to determine if ongoing services are necessary.

In summary, the data collected in the evaluation process must be

- relevant to the specific concerns or questions that were raised
- multidimensional (include the environment, the curriculum, the child's performance, and performance of peers)
- provide a reliable and valid baseline for decision making.

Development of the IFSP and IEP

The purpose of team meetings is to develop, review, or revise the IFSP or IEP. Because team members must decide on program and service needs, it is critical that OT practitioners have input into the development of the child's individualized plan or program. The team is responsible for reviewing and listing the child's or family's needs and appropriate services. When the practitioner cannot attend, he or she should provide written documentation to the team concerning the nature, frequency, and amount of services recommended (see Table 7.3).

The IFSP is developed by family members, the designated service coordinator, and other specialists, as needed. Specific components are listed in Table 6.1B. The family's priorities and needs for their infant or toddler should guide this process. The occupational therapist, as a primary service provider, could be the designated service coordinator for the child and family.

The outcomes should reflect the needs of the child and family and should list criteria, procedures, and time lines that provide ongoing evaluation of those services. Early intervention services, such as occupational therapy, must document on the IFSP the frequency, intensity, method of service delivery, and environment.

EXAMPLE

Development of an Individualized Family Service Plan (IFSP)

Persons Present. The people who helped create the IFSP were Madison, her parents, the social worker (initial service coordinator), the early childhood special education teacher (ECSE), the occupational therapist, the physical therapist, and the hospital nutritionist. The latest report from Madison's physician was also present.

Discussion of Madison's History. Madison is 5 months old. She was referred to this agency because of developmental delay and poor weight gain. She was born full-term with no significant complications. However, her parents noticed that Madison had difficulty sucking from the bottle and that her arms and legs seemed stiff. A team consisting of the ECSE teacher, occupational therapist, physical therapist, and social worker evaluated Madison in her home with both parents present. The hospital nutritionist also evaluated Madison at the request of both the physician and the parents. Vision and hearing screenings were conducted through the local education agency and were normal.

Discussion of Madison's Current Skill Levels and Needs. During the evaluation in the

TABLE 7.3—REQUIRED IEP/IFSP MEETING PARTICIPANTS

Part H	Part B
Parents or guardians, family members, service coordinator, and other specialists, as needed.	Student's teacher, representative of the local education agency (LEA) who can provide and supervise the provision of special education, parents or guardian, other individuals at parent's or agency's discretion, and the child (if appropriate).

TABLE 7.4—EXAMPLE OF STRATEGIES OR ACTIVITIES, CRITERIA, AND TIME LINES FOR IFSP

Outcome #1	Outcome #3
Madison will grow and gain more weight.	Madison will reach for objects and turn her head to look for objects or sounds.
Strategies/Activities	**Strategies/Activities**
Madison's weight and height measurements will be taken monthly at doctor's office. The occupational therapist will plot measurements on growth chart, send to nutritionist, and work weekly with Madison to improve bottle-drinking skills and to initiate spoon feeding. Nutritionist will contact family every 3 months.	The therapist and ECSE teacher will work with Madison on a weekly basis. Activities include locating sounds that are highly motivating to Madison, rewarding her for looking while someone talks to her, locating objects or textures that she enjoys, placing objects nearby her while she is in a variety of positions, and encouraging her to explore them with mouth or hands.
Criteria and Time Lines	**Criteria and Time Lines:**
Will gain at least 1.5 pounds per month. Will eat at least 5 spoonfuls of cereal per meal. Will eat at least 1/4 cup of baby food cereal by July 1.	Will turn head to familiar voice by December 1. Will reach for object placed near her hand when she is sitting with support by July 1.

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home, the team observed that Madison startled when she heard a noise but did not search with her eyes for the sound or interact when adults talked to her. At rest, her hands were open and by her side. Exploration of objects with her hands or mouth was not yet possible since she did not reach forward to touch objects. Madison's parents reported that she enjoys being held and rocked and that she awakens to eat only once during the night. When Madison was held at her parent's shoulder, she was able to momentarily lift her head. When she was lying on the floor or in her crib, she did not turn her head or attempt to roll. Overall, her performance was significantly delayed, and early intervention services were recommended. The nutritionist reported that Madison's caloric intake was less than was needed for adequate weight gain and growth. A special formula was recommended as well as ongoing nutrition consultation.

Discussion of Family's Needs and Strengths. Madison's parents both work outside the home. Madison is cared for by her aunt who has a child-care program in her home. There are no siblings, although Madison's parents report that they would like to have more children later. Recently, they switched to a new insurance company, which appears to be providing better coverage. Their primary concerns at this time have to do with Madison's development. They would like to see her grow, gain more weight, and learn to hold her head up when she is sitting. They wonder if she will ever learn to look for and grab toys. Since they have not been around other infants, they do not know what babies should be doing at this age. Although Madison's parents are gone during the day, they expressed a desire to be taught activities in their home in the evening.

Outcomes. The needs expressed by the family became the outcomes. They were documented on the IFSP as follows:

1. Madison will grow and gain more weight.
2. Madison will learn to hold her head up when she is sitting.
3. Madison will reach for objects and turn her head to look for objects or sounds.
4. Madison's parents will become aware of various developmental milestones and activities to facilitate Madison's development.

An example of the strategies or activities, the criteria, and the time lines is presented in Table 7.4 using Outcomes #1 and #3. Table 7.5 shows the early intervention services.

Service Coordination and Date of Next Review. The occupational therapist was chosen as the service coordinator since interagency collaboration (with nutritionist and physician) was already part of the responsibilities included in the shared outcome. The next review was scheduled for 6 months later.

Individualized Education Program (IEP). This plan is developed by a student's teacher, a representative of the agency (i.e., principal), parents, and other persons, such as the occupational therapist. Specific components of an IEP are listed in Table 6.1B.

The student's present level of education performance (PLEP) and the annual goals should be directly related. The goals should be reasonable expectations of the student's behavior within the school year or a 12-month time period. Objectives are measurable and are intermediate steps between the PLEP and the annual goals. These objectives are very important because they serve as a benchmark to measure progress toward the goal. Overall, the goals and objectives identify the unique and specific concerns that are interfering with the

TABLE 7.5—EARLY INTERVENTION SERVICES ON MADISON'S IFSP

Services	Occupational Therapist	ECSE	Physical Therapist	Nutritionist
Outcomes	#1, 2, 3, 4	#1, 2, 3, 4	#2, 4	#1
Frequency	4 times/month	4 times/month	2 times/month	once/3 months
Intensity	45 min/session	45 min/session	60 min/session	45 min/visit
Method	with baby and ECSE	with baby and OT	1:1 baby	1:1 family
Environment	home (2x)/aunt (2x)	home (2x)/aunt (2x)	home/aunt	home
Service Initiation	July 1, 1996	July 1, 1996	July 1, 1996	July 1, 1996
Services Duration	July 1, 1997	July 1, 1997	July 1, 1997	July 1, 1997

child's educational performance. There is only *one* IEP for a student, not an IEP for each related service provided. The team develops the goals and determines the appropriate programs and related services. IEP goals and objectives developed before the IEP (computerized or otherwise) meeting tend to bypass the concept of the team and do not include the parents as equal participants in developing the student's program.

EXAMPLE

Development of an Individualized Education Program (IEP)

Persons Present. The people who helped create the IEP were Ashik's parents, principal, regular education teacher, special education teacher, and occupational therapist.

Discussion of Ashik's Strengths. Ashik is an 8-year-old boy in second grade. He participates in all activities and enjoys interacting with peers. Reading and music are his favorite subjects. His parents report that Ashik tries to complete all homework assignments. He is independent in his wheelchair mobility and self-help skills at schools.

Discussion of Ashik's Present Level of Educational Performance (PLEP). Ashik knows basic addition facts, but not subtraction. He enjoys reading and is currently reading kindergarten-level books. Ashik can communicate his ideas orally, but not in writing because his writing is illegible.

Discussion of Ashik's Annual Goals. The goals agreed upon and developed by the team include the following:

- Ashik will learn and use subtraction facts needed for second grade.
- He will read books that are appropriate for beginning second grade.
- He will complete written work using complete sentences and will write legibly.

Discussion of Educational Service Options and Team Recommendations. The team agreed that Ashik should remain integrated

into general second grade, with the school's resource teacher providing services within that setting as well as within the resource room, when appropriate. The second grade and resource teachers will be responsible for all objectives under the first and second goals. Since Ashik's written communication (handwriting) skills have become significantly delayed and are interfering with classroom work, OT services are recommended. These services should include consultation with teachers, hands-on therapy with the child, curricular modifications, and equipment to increase participation in classroom work. The teachers, occupational therapist, and certified occupational therapy assistant (COTA) will be responsible for all three objectives under the third goal. Lunchroom modification, using a lunchroom table with a special extension to accommodate a wheelchair, shall continue.

Special Education Services. Resource—1 hour per day; occupational therapy—90 minutes per month.

Frequency and Duration of OT Services. Although the occupational therapist makes recommendations to the team regarding the frequency, nature, and amount of services, the team makes the final determination. Giangreco (1996) lists criteria such as the following to determine educational necessity of support services:

- Would the absence of this proposed service interfere with the student's access to, or participation in, the IEP?
- Do the service recommendations of the team members present any undesirable or unnecessary overlap or contraindications?
- Can service provided in one context be adequately generalized to other settings without the direct involvement of the specialist?

Justification for OT services should be included in the written report and based on actual problems in student performance in the performance context. For example, the recommendation for OT services should consider resources and supports available to the child. Some teachers may have been trained in specific feeding techniques that they could use when feeding a child, while another teacher may be new to children with disabilities and may require more time to learn these methods. Some children may be able to develop skills that are age-appropriate, while other children may never develop skills past the 3-month level of functioning. While a continuum of services may be available for each child, the frequency, nature, and amount of services should reflect the uniqueness of that child and his or her environment on the basis of the child's current needs.

Services must be clearly stated on the IEP and cannot be changed without holding another IEP meeting. Adjustments in scheduling those services can be made without another IEP meeting, although parents should be notified. For example, the team may decide to recommend 80 minutes per month for OT services, thus allowing the therapist to adjust that time around the changing school year (e.g., initially 20 minutes per week to work with the child and to train teachers, and then changing to 40 minutes every 2 weeks to observe the child in various settings). Clear and ongoing documentation of the child's behavior during intervention should provide data for deciding about future needs and the level and amount of services.

TABLE 7.5—EXAMPLES OF ASHIK'S SHORT-TERM OBJECTIVES FOR GOAL THREE

Given a marker, a slanted surface such as a 3-inch notebook, and a written model of his oral comments, Ashik will copy a five-word sentence (all words legible) for five consecutive assignments.

Given a pencil, a slanted surface, and verbal instruction, Ashik will write a simple sentence (all words legible) for five consecutive assignments.

When given written work assignments, Ashik will use complete sentences (all words legible) for 90% of the assignments in a week.

The IEP must be reviewed annually. It is entirely appropriate for certain students to have their IEP reviewed more frequently and to have intermittent checks on performance built into the review process so that services can be adjusted or ended if no longer necessary. It may be that a full year of services is not needed. Indeed, the concept of intervention units, similar to what is used in fee-for-service situations, has been used by some school systems to indicate the commitment of resources and to give flexibility to the implementing team. This flexibility allows team members to distribute the intervention over the course of the year in response to changing student needs. The needs of each student should be the driving force behind how services are determined and provided. The system should serve a student's needs, not the other way around.

Intervention. All activities that an occupational therapist or COTA may do on behalf of a client should be considered occupational therapy. Practicing from a holistic perspective requires that all aspects of occupational functioning be addressed. All of the following activities should be considered intervention:

- working with the child directly
- modifying the home or school environment
- working with the teacher to identify alternative ways for the student to demonstrate competency or understanding of a concept
- developing a dressing routine for daily implementation by an aide
- contacting a physician about a student's recent operation
- meeting with the school psychologist to combine progress information into a report to the family
- reevaluating.

Each activity requires professional time, knowledge, and experience, and reflects the appropriate use and commitment of the resources that the team (acting on behalf of the LEA) said, within the IEP or IFSP, would be used on the student's behalf. Documentation of those activities is part of the intervention and must not be dis-

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counted or disregarded in a calculation of professional time. Earlier versions of a student's IEP or ISFP may have contained models of service delivery (consultation, direct, monitor) that are no longer appropriate. As in other settings, OT service delivery is dictated by the current and ongoing needs of the client and should be flexible, using various options across the continuum of service delivery (AOTA, 1995a).

The use of aides, teacher assistants, parent helpers, peer helpers, teachers, and others is widely practiced in many school settings. This involvement provides the student with carryover of specially assigned or suggested activities as part of the daily routine but is *not* considered to be OT services. If such assistance is documented on the IEP, it should be clearly listed as activities provided by an aide or non-OT staff.

An OT aide, as defined by AOTA (1995c), is an individual assigned by the occupational therapist to perform "delegated, selected, skilled tasks in specific situations" under intense and close supervision of an OT practitioner. The appropriate use of aides in early intervention and school-based practice can contribute to greater efficiency and more cost-effective use of services provided by the OT practitioner. The therapist must exercise care, however, when deciding what tasks to delegate to the aide. At no time should the child's safety be jeopardized. The occupational therapist is ultimately responsible and accountable for the use of aides in the course of providing OT services, including the initial training and guidance. The intensity of supervision is determined by the nature of the task to be performed, the needs of the client(s), and the capability of the aide.

An *intervention plan* is developed by the occupational therapist, with assistance from the COTA (as appropriate), using the evaluation data and the individual's expected outcome after intervention. This plan is *not* the same as the IEP or IFSP; but rather it reflects the *Philosophical Base of Occupational Therapy* (see Tables 7.7 and 7.8).

The OT practitioner must carefully choose the methods for determining the effectiveness of the intervention plan, using permanent products (worksheets, grades) or data collected by observation. Well-defined behavior, baseline performance data, and ongoing data collection promotes effective practice.

Planning for discontinuation of OT services should begin at the time that initial services are being recommended. What skills will the child, teacher, or family need once OT services are discontinued? What other supports and services, if any, will the child, family, or teacher need? How can the OT practitioner facilitate the linkage to other services or programs?

Assistive Technology. Congress made a significant addition to IDEA when they reauthorized it in 1990 by specifically addressing assistive technology. At the same time, Congress coordinated the terminology used to describe assistive technology devices and services under IDEA with the language used in the Technology Related Assistance for Individuals Act of 1988. Technology, both high-tech and low-tech, is considered a special education and

early intervention service. Very often, the kinds of activities that are needed to select, design, fit, customize, adapt, repair, or replace assistive technology devices or to train people to use them are activities that require maximum flexibility in terms of intervention methods. Providing appropriate assistive technology services requires coordinating and consulting with other professionals. Assistive technology needs should be included in the IEP or IFSP.

Student Load or Workload. Three basic functions in pediatric services provided under IDEA include evaluation, intervention, and program planning and evaluation. Evaluation and intervention are tied to specific student, child, or family circumstances. Both of these services involve planning, implementing, evaluating, and documenting the implementation of intervention. Program planning and program evaluation are more comprehensive processes and involve looking at service delivery processes in a quest for greater efficiency and effectiveness. Although previous guidelines have referred to student load or workload as *caseload*, increasing sensitivity requires a change to a more child-centered terminology.

Greater flexibility in service delivery requires flexibility in determining student load or workload. Student load or workload determination is essentially an administrative issue within each jurisdiction. Previous guidelines have recommended a student load range of 16 to 43, depending on the type of intervention, frequency of intervention, and travel expectations.

When determining a reasonable workload for a given number of hours, the following variables should be considered:

- amount of intervention time designated to OT practitioner on child's IEP or IFSP
- type and amount of new referrals for evaluations
- prereferral or problem-solving activities
- geographic area to be covered by the OT practitioner and amount of travel time required
- corollary duties required of the practitioner (such as inservices to other staff members, required inservice attendance, or staff meetings that are not specifically child focused)
- amount of support available from aides, assistants, and clerical personnel
- amount of time needed for teaming with staff, parents, and other agencies
- supervisory duties of other staff (COTA, aides)
- amount of time needed for agency and professional documentation
- time commitment as service coordinator or case manager.

Therapists who find that they cannot meet all the responsibilities placed on them by an agency must discuss the problem with their administrator. Practitioners can educate supervisors about the extent of services they provide by producing a list of required time commitments per week or per month. Achieving a more manageable workload may require compromise. Creativity in scheduling students (such as basing needs on individual criteria rather than assigning children to 30-minute or 60-minute weekly slots) may allow more

TABLE 7.7—OCCUPATIONAL THERAPY INTERVENTION PLAN

Name: Madison | Birth Date: 01/26/96 | School District: Bellview, home visit

Precautions: N/A | Frequency/Duration of OT Services: 45 minutes/week

Strength/Weakness (Present Level of Performance) Baseline

Hands open at rest—no reaching for objects or hands to mouth observed

Head control emerging when held against adult's shoulder—no head turn or head control in other positions noted

Unable to roll to side but allows handling and enjoys movement

Hearing and vision normal; doesn't localize to sound

Can drink from a bottle; oral-motor skills delayed; weak sucking skills

Priorities Among OT Intervention Goals and Objectives (Not to Appear on IFSP)

Madison will demonstrate shoulder stability needed and will reach for and bat at objects.

Madison will demonstrate head-righting reactions and cocontraction of neck muscles.

Madison will demonstrate coordination in cheeks, lips, and tongue to facilitate oral-motor patterns during bottle drinking and spoon feeding.

Madison will localize sounds by turning her eyes or head in that direction.

IFSP Outcomes

Madison will reach for objects and turn head to look for objects or sounds:

1. turn to familiar voice by 12/1
2. explore hands by 12/1
3. reach for objects near her hand when she is sitting by 6/15.

Madison will grow and gain weight:

1. gain 1.5 lbs/month
2. eat at least 5 spoonfuls of cereal by 12/1
3. eat 1/4 cup of baby food by 7/1
4. learn to hold her head up when sitting.

Strategies and Methods, Environment, and Others Used to Address OT-Related Needs

Madison will be cotreated weekly by ECSE teacher and OTR. Environment will alternate between child care in aunt's home and in Madison's home with parents at 5:00 p.m.

Activities to facilitate:

1. neck stability and righting reactions
2. shoulder stabilization to allow movement of arm (supine)
3. head turning to and across midline
4. coordination of oral-motor skills, especially lips, tongue, cheeks.

Positions to emphasize:

1. supine
2. side lying
3. prone on inclined surfaces
4. sitting on adult lap.

Share developmental information with parents.

Plan for Reevaluation; Method of Data Collection; Discharge Planning

Weekly observation and documentation on visual chart regarding progress toward outcomes.

Discharge to occur when Madison has met these outcomes and no additional outcomes require OT intervention services.

Source: Form reprinted with permission from Gloria Frolek Clark, Heartland AEA.

TABLE 7.8—OCCUPATIONAL THERAPY INTERVENTION PLAN

Name: Ashik Birth Date: 03/09/88 School District: Appletown, USA, school visit

Precautions: N/A Frequency/Duration of OT Services: 90 minutes/month

Strength/Weakness (Present Level of Performance) Baseline

Ashik orally communicates ideas but has difficulty with writing.

1. He can correctly form 15:26 alphabet letters but works slowly. In 2 min could write only 10 letters from memory.
2. He currently skips letters and omits proper spacing when copying words.
3. He can copy words of 3–4 letters from chalkboard.
4. He can grasp pencil functionally but holds pencil too tightly.
5. His visual-perceptual skills are delayed, as seen when comparing his work with his peers. Spacing and reproduction of letters are difficult.

Priorities Among OT Intervention Goals and Objectives (Not to Appear on IEP)

Ashik's visual motor skills will demonstrate improvements as noted by

1. appropriate spacing of words and letters
2. appropriate sequencing of words and letters
3. ability to reproduce basic shapes and all letters of alphabet.

Interference from Ashik's postural tone and hand grip will be decreased through relaxation, exercises, myofacial release to hand and arm; team members will use verbal reminders and try various writing tools.

Student IEP Goals and Objectives

Ashik will complete written work using complete sentences.

1. Given a marker, slanted surface, and written model, he will copy a five-word sentence, all words legible, for five consecutive assignments.
2. Given a pencil, slanted surface, and verbal instruction, he will copy a simple sentence, all words legible, for five consecutive assignments.
3. Given written work assignments, he will use complete sentences, all words legible, on 90% of assignments.

Strategies and Methods, Environment, and Others Used to Address OT-Related Needs

Provide OT 90 min/month, including

1. Meet with teachers to set up and monitor activities for drill or practice in schools—alphabet cards for copying from model
   - worksheets with emphasis on visual/spatial awareness
   - modified curriculum to add other activities to facilitate these skills.
2. Work with Ashik during written work time, resource, or free reading time to assess current skills, develop new skills, and model appropriate strategies for teacher.
3. Communicate progress to parents on an ongoing basis.
4. Review written classwork.

Plan for Reevaluation; Method of Data Collection; Discharge Planning

Develop a graph for teachers or parent to collect data weekly on number of alphabet letters correctly written from memory in 2 min.

Develop a graph for teacher or helper to collect and document number of correct words from five-word sentence twice a week.

OT provider and teacher to review graphs every 2 weeks and review classroom written work samples to assess progress.

Discharge planning will occur when Ashik has met these goals, unless other concerns in educational program are noted.

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Source: Form reprinted with permission from Gloria Frolek Clark, Heartland AEA.

flexibility. For instance, the practitioner may observe child A in art one week and in the lunchroom the next week. The schedule must allow for such flexibility. Some practitioners schedule by the school or location; for example, they'll go to one elementary school on Monday morning (five students with frequencies of two once a week, two every other week, one monthly) and on Monday afternoon will go to community job training sites, followed by teacher collaboration after school.

Documentation of IFSP and IEP Outcomes

Documentation accomplishes four goals: facilitates effective treatment, provides communication among team members and the family, justifies reimbursement, and stands as a legal record (McClain, 1991). Poor documentation can have ethical, financial, and legal consequences. The rules of documentation for any work setting involve the client's needs in that setting, the team, the payer, and governmental and agency regulations. Certain federal legal requirements exist for documenting the provision of special education and related services and early intervention services under IDEA. Briefly, the documentation process should reflect the referral for evaluation, the evaluation to determine eligibility, the IEP or IFSP, progress notes or a record of interventions, and due process (Greene, 1992).

The steps in documenting the OT process closely mirror federal requirements, with variations from state to state. The steps include the evaluation, the intervention plan, the intervention, and the reevaluation. Individual facilities and government agencies also may require specific documentation formats and deadlines. IDEA allows for early intervention programs and school programs to bill third-party payers, including Medicaid, for OT services provided as part of the IFSP or IEP (34 C.F.R. §300.301 and §303.522). Documentation for reimbursement must conform to the rules and regulations of those agencies; however, a single documentation system can be developed to reduce confusion among the professionals who bill for services (Lewis-Jackson, 1994). The challenge is to prevent the reimburser from "driving" the documentation or service delivery.

The federal Family Education Rights and Privacy Act of 1974 (FERPA) (Pub. L. N. 93–380), along with IDEA, specifies confidentiality requirements and restricts access to a student's educational record to parents, adult students, and certain other authorized persons. An educational record is "directly related to a student, and ... maintained by an educational agency or institution or a party acting for the agency or institution" (34 C.F.R. §99.3(a)(1)(2)). This description includes records prepared by contractors of services as well as by employees of a school system. A special education student's record includes personally identifiable information, reports, clinical evaluations, progress notes, samples of student work, grades, and other materials used by educational personnel to make placement and other decisions regarding that student. The educational record may be called the *cumulative file, permanent record,* or *official educational record.* Documentation of the complete

process is essential and should be written in a language that is compatible with other educational documents.

Large workloads, frequent meetings, and travel are realities in the lives of school and early intervention OT personnel. Often, little time left is in the weekly schedule for documentation that is essential for legal protection. In school settings, practitioners must use their time efficiently and must eliminate all unnecessary information. Using computerized systems and dictating letters, evaluation information, and progress notes can save time. Practitioners can select from many reporting methods that will streamline the process, such as flowcharts, checklists, fill-in-the-blank forms, color coding, and routine introductory and explanatory paragraphs that can be inserted into evaluation reports and letters without having to be rewritten.

The following general considerations should be made when documenting OT services under IDEA:

1. Consider the reader so that the information will be clearly understood. The professional language of the OT practitioner must be adapted to meet the demands of the environment. When communicating with educational personnel and parents, use nonmedical language and avoid professional jargon.
2. Documentation must indicate a functional goal, particularly if the program bills Medicaid or other third-party payers. OT practitioners will need to be aware of specific documentation requirements to meet the payers' guidelines for reimbursement.
3. Be specific when observing a child's performance. Collect measurable data that can be used as a baseline. Look at strengths as well as needs.
4. Write information in an organized, logical, and legible manner.
5. Use correct spelling and grammatical structure.
6. Provide accurate and current information.
7. Type formal reports that will be included in the official record.
8. Make reports brief enough to be read but long enough to be meaningful and useful.
9. Sign all forms of documentation with your full name (no nicknames) or with your first initial and last name, followed by the appropriate professional designation.
10. Provide actual information on how the child's physical and psychosocial behaviors affect participation in education or development.
11. Have the supervising OTRs countersign documentation written by OT students.
12. Use complete words, not abbreviations.
13. When changes are made to documentation that are part of the official record, draw a single line through the error and initial the correction. Do not use correction fluid or correction stickers. In the event of litigation, it is essential that the error and correction be visible and legible.
14. Date all documentation.

Other Types of Documentation

Progress Notes. The continuation of OT services in the educational and early intervention setting should be justified by evidence of the child's needs and team decisions. Progress notes should include the following:

- activity or procedures used
- child's response to intervention and measurable progress or lack of it (including reasons child may not have responded)
- modification of goals indicated by response to intervention.

Progress notes can be kept in the personal files of OT personnel. A summary of progress toward the goals or outcomes should be included in the child's permanent record as needed to reflect his or her current status. This summary should also be placed in the permanent record and sent to parents quarterly (as report cards are) or on a basis established by the team. All information written by an OT assistant and included in the permanent record should be reviewed by the supervising occupational therapist before inclusion. A copy of any written instructions to a parent, teacher, or student should also be kept in the record, such as instructions concerning proper care of adaptive equipment or programs to be carried out in the classroom or at home.

Discontinuation Notes. When a child is discontinued from OT services by the team, a summary should be written by the therapist that includes the following information:

- child's name
- date of discontinuation
- school, class, teacher, and program
- length of time OT services were received
- summary of OT services received and functional status at time of discharge
- reasons for discontinuation
- performance on current IEP goals or IFSP outcomes related to OT service
- planned follow-up or transition.

Communications or Contacts. The practitioner should keep a record of contacts made by telephone or letter with parents, doctors, and teachers and should include a brief summary of information or subjects discussed.

PROGRAM-SPECIFIC OUTCOMES

Standard IX of the "Standards of Practice for Occupational Therapy" (AOTA, 1994a) discusses the OT practitioner's responsibility for monitoring and documenting the continuous quality improvement of practice, monitoring the effectiveness of OT services, and reviewing systematically the success or appropriateness of interventions. The overall objective of OT services in schools is to improve the student's educational outcomes, whereas OT services in early intervention and preschool programs are targeted toward improving the child's developmental outcomes, which can lead to better educational outcomes later on. These objectives are true whether services are provided under IDEA, Section 504, the ADA, School-to-Work, or Head Start.

The "Sixteenth Annual Report to Congress on the Implementation of the

Individuals with Disabilities Education Act" (U.S. Department of Education, 1994) states that very little information is available about educational results for students with disabilities. What is known, however, is that performance of students with disabilities is more likely to be influenced by the proportion of time spent in general education academic classes than by the placement alone. Other factors influencing school performance include absenteeism, class or grade failure, poor reading ability and poor performance on school-related tasks, lack of involvement in school or community groups, and lack of work or vocational experience (Wagner, Blackorby, Cameto, Hebbeler, & Newman, 1993). Students with serious emotional disturbance tend to have even poorer educational outcomes and graduation rates and are more likely to be involved with the juvenile justice system than are other students with disabilities.

Appropriate outcomes for early intervention and preschool programs are those that "facilitate the achievement of optimum development through the provision of evaluation, education, and/or therapeutic services to children with disabilities or to children who are at risk of developmental delays and to their families" (CARF, 1995). Families are viewed as the primary decision makers in identifying service needs and in delivery of those services.

Accountability

The outcomes for children receiving OT services under IDEA programs must involve accountability. How human services are being provided has changed fundamentally, and education and early intervention are no exceptions. All activities are open to scrutiny as to their effectiveness in achieving their stated goals. What was the outcome of services? Would the outcome have been any different if OT services had not been provided? Accountability asks these essential questions. Any discussion of accountability for OT services under IDEA must address student or child and family outcomes (client of services), programmatic outcomes, and fiscal outcomes.

Individual Outcomes

Individual outcomes, that is, of children who are recipients of services, are the type of outcome with which practitioners are most comfortable. These outcomes are tied directly to the therapeutic process and, for many practitioners, help define their identity as therapeutic practitioners. The fundamental question is "Was there positive change for an individual because of the intervention of occupational therapy?" The most efficient method for reviewing individual outcomes is by documenting the intervention and using precise language. Comparisons at regular intervals will provide the essential information.

Programmatic Outcomes

Programmatic evaluation is an often neglected yet vital part of OT service delivery. Outcomes are inextricably tied to context. It is insufficient to address individual outcomes without considering how those outcomes might have been affected by the way a particular program provided services. Programmatic evaluation is based on the individual characteristics (or qualities)

of the program and on its specific mission or purpose. The problem-solving process of programmatic evaluation will find out what the actual outcomes of your efforts are. Golubock and Reed (1992) provide a schemata to illustrate this (see Figure 7.1).

What is the purpose of special education or early intervention? The purpose drives the people (clients of services and service providers) to create policies (general guidelines or specific rules) that are implemented as procedures (time lines, assessment standards). The procedures as a whole create various products (IEPs, IFSPs, annual reports). The products should show how the entire process supports the original purpose.

Programmatic evaluation always assumes the program or its outcome could be improved. The OT practitioner is responsible for monitoring and documenting how to continuously improve the quality of practice (such as outcomes of services) using predetermined practice criteria. Effectiveness and timeliness of services, as well as discontinuation of services, must meet a prescribed standard.

Fiscal Accountability

General concerns about the financing of social services, education, and health care in the United States and, in particular, concern for children with special needs have caused a significant shift in how such services are being provided and funded. Added to the debate are the growing numbers of children being identified for services; a chronic shortage of qualified OT practitioners in schools, early intervention, and preschool programs, with the resulting need to "contract out" for services; and a recognition that the service delivery mechanism has shifted to include fewer OT practitioners to provide the traditional hands-on approach to intervention and more non-OT staff members.

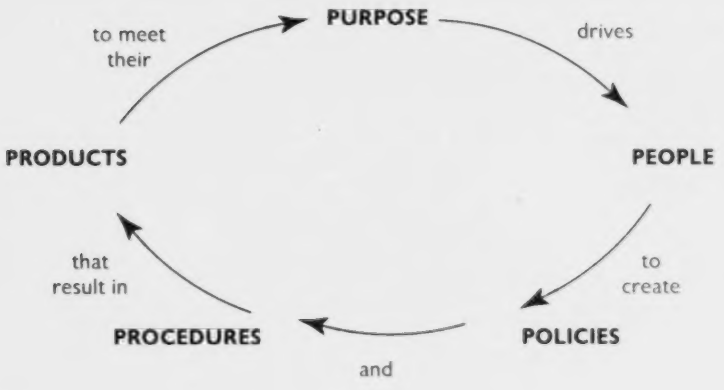
Practitioners and program administrators must decide how to allocate resources and time to best meet the needs of their clients and determine if the outcome of the intervention is worth the cost. Therapy practitioners also have to assess the appropriateness of interventions as newer technologies and service delivery approaches become available (Lawlor, 1991).

Documentation of Program Outcomes

Program Management and Development. Occupational therapy practitioners working in school systems should develop the type of administrative records necessary to manage the OT program and plan for future services. Practitioners should work closely with the administrative staff in the local education agency to develop the reporting forms and procedures. The following are some examples of administrative records that can be used in the educational setting:

- A *record of each student referred*, the reason, the source of the referral, and if the student qualified for occupational therapy will be useful in determining if inappropriate referrals are being received, and it will identify areas needing further attention.
- A *record of student intervention* can be used to record the date, type, and length of intervention sessions. Such records

FIGURE 1: A PROBLEM-SOLVING PROCESS OF PROGRAM EVALUATION



Source: Golubock & Reed, 1992

will show when and why a student failed to receive service.

- *Weekly or monthly schedules* will show when and where OT personnel will be during the scheduled period. Student intervention, consultation, IEP meetings, and similar information may be included. This information is helpful in locating an itinerant practitioner who may be in a different school each day. OT personnel should have flexible schedules because of the need to travel and respond to unexpected situations.
- *Statistical records* by the month or year should report the number of students referred and/or are receiving services, total number and type of services provided, number of evaluations, and number of students discharged. Such records are important justifications for program expansion or recommendations for changes in service delivery.
- *Equipment and supply records* should be kept by school-based OT personnel. This master list of testing and assessment tools and other equipment should be checked at the end of each school year for needed repairs or replacement. If adaptive equipment, mats, balls, or other items are loaned to others during the year, a record of individual items (checked in and out) should be maintained.

Effectiveness of Occupational Therapy

Evaluating the overall quality of OT services should include evaluating the entire program as well as each child and family who receives OT services. Individual outcomes can be documented easily using

FIGURE 7.2. PROBLEM-SOLVING MODEL

Source: Reprinted with permission from Heartland Area Education Agency.

measures of progress on the IEP goals and objectives or IFSP outcomes. Program outcomes can be evaluated by determining the number of children who met their goals or outcomes and noting the reasons others did not.

OT practitioners should be aware of their state education and early intervention agencies' efforts to document services and effectiveness of those services. Agencies or departments may have developed 3-year plans with annual goals and objectives. How are these goals monitored? What input does the staff give? How are these goals chosen? Using a problem-solving model, such as that shown in Figure 7.2, the OT program may want to work through this process to identify concerns and develop action plans. Each department and agency should develop long- and short-term goals. Occupational therapy practitioners should become involved in this goal-setting process as a way to enhance services for children and youth under IDEA.

The outcome should enhance program effectiveness, and continuous engagement in this process should yield continuous quality improvement.

Occupational Therapy Roles for Practice in Early Intervention and the Schools

Table 7.9, on the following pages, shows roles for occupational therapists and

TABLE 7.9—ROLES FOR THE OCCUPATIONAL THERAPY PRACTITIONER IN EARLY INTERVENTION, PRESCHOOL, AND SCHOOL SETTINGS

Key: X = completes task alone
A = assists (cannot complete task alone)
– = does not perform this task

OTR - Occupational Therapist, Registered COTA - Certified Occupational Therapy Assistant

Task	OTR			COTA		
	Entry	Intermediate	Advanced	Entry	Intermediate	Advanced
A. Screening and Evaluation						
1. Assist the person initiating the screening or evaluation questions in clarifying the child's current performance in the areas of concern, the expected level of performance (behavior desired), the modifications or attempts that have been made to solve the problem, and the results of those attempts.	X	X	X	A	A	A
2. Screen and evaluate child to determine significance of the discrepancy between child's current performance and expected developmental performance. Identify possible interfering factors.						
a. Collect information regarding child's performance using various methods from multiple settings and sources.	X	X	X	A	A	A
(1) Observe skill as it occurs in natural setting.						
(2) Review child's records, report cards, etc.						
(3) Interview parents, caregivers, teachers, and pertinent others.						
(4) Communicate with other agencies and medical staff.						
b. Determine child's current functional abilities in performance areas (activities of daily living, work/productive activities, and play/leisure activities) as compared to the expected performance.	X	X	X	A	A	A
c. Determine child's current functional abilities in performance components (sensorimotor, cognitive, and psychosocial) as compared to expected development.	X	X	X	A	A	A
d. Determine child's current functional abilities within performance contexts, including temporal context and physical, social, and cultural environmental contexts, as compared to the expected performance.	X	X	X	A	A	A
3. Interpret screening results and determine if further testing is necessary.	X	X	X	–	–	–
4. Refer child to other appropriate professionals when child's needs exceed the OT practitioner's expertise.	X	X	X	–	–	–

Table 7.9 (continued)

Task	OTR Entry	OTR Intermediate	OTR Advanced	COTA Entry	COTA Intermediate	COTA Advanced
5. Use evaluation methods (observation, child's products, assessment tools) that focus on the initial problem; provide input that can be used to develop intervention strategies and that consider the child's performance within the natural setting.	X	X	X	A	A	A
6. Synthesize and summarize information in a report to document referral, interpret evaluation results, describe current level of the child's performance, and provide recommendations and strategies relating to the initial evaluation question(s).	X	X	X	A	A	A
7. Supervise COTA for activities and skills that have been established.	X	X	X	–	A	A
B. Program Planning						
1. Participate in the IFSP or IEP process through oral and written communication at the meetings.	X	X	X	A	A	A
2. Interpret child's performance and interfering factors as indicated through the evaluation process and as related to the evaluation questions.	X	X	X	–	–	–
3a. With the multidisciplinary team, determine family needs, develop family-centered outcomes, and recommend OT when needed to achieve IFSP outcomes.	X	X	X	A	A	A
3b. With the educational team, determine student needs, develop goals related to academic and nonacademic performance, and recommend OT service delivery when educationally necessary (IEP).	X	X	X	A	A	A
4. Recommend to the team the frequency and duration of OT intervention when the team has determined OT service to be necessary to the IFSP or IEP.	X	X	X	–	–	–
5. With other members of the team, develop activities and time lines for the developmental outcomes (IFSP), or write objectives that reflect the student's needs in the educational setting (IEP).	X	X	X	A	A	A
6. Determine skills the child, teacher, and family need to possess for OT services to be terminated.	X	X	X	A	A	A
7. Develop an OT intervention plan.	X	X	X	A	A	A
C. Intervention						
1. Plan for and deliver OT services according to the frequency and duration listed on the IFSP or IEP.	X	X	X	A	A	A
2. Develop and implement a plan of data collection to provide objective basis for decision making (ongoing evaluation).	X	X	X	A	A	X
3. Provide intervention that enhances the child's functional abilities in performance areas and in performance components.	X	X	X	A	A	A

Table 7.9 (continued)

Task	OTR Entry	OTR Intermediate	OTR Advanced	COTA Entry	COTA Intermediate	COTA Advanced
4. Provide intervention that considers child's performance within contextual aspects (temporal and environmental).	X	X	X	A	A	A
5. Alter intervention plan as indicated by child's performance (documents in record).	X	X	X	A	A	A
6. Identify and address ethical dilemmas and issues that may develop.	X	X	X	X	X	X
7. Fabricate and customize basic technology solutions as needed (splints, switches).	X	X	X	A	X	X
8. Contribute information in meetings, conferences, and informal interactions.	X	X	X	A	X	X
9. Determine need for reevaluation.	X	X	X	A	A	A
10. Document child's performance, phone calls, meetings, and such in child's OT record.	X	X	X	X	X	X
11. Provide appropriate training and supervision to family and non-OT personnel who supply activities within the daily routine.	X	X	X	A	X	X
12. Provide appropriate level of supervision to COTA who provides interventions.	X	X	X	–	A	A
13. Critically analyze and apply current research related to early intervention or to school practice.	X	X	X	A	A	A
14. Conduct studies to determine effectiveness of OT services in early intervention.	X	X	X	A	A	A
D. Coordination						
1. When designated by the team, act as IFSP service coordinator or IEP case manager.	X	X	X	–	A	A
a. Actively involve student, family, other team members, and other agencies in appropriate aspects of child's program.						
b. Schedule and invite appropriate persons to review meeting.						
c. Coordinate meeting, including completing appropriate forms.						
d. Perform other responsibilities designated for the service or case coordinator.						
2. Track child's record to determine when reviews are scheduled.	X	X	X	X	X	X
3. Demonstrate awareness of legislation and current trends in school and early intervention practice.	X	X	X	X	X	X
4. Participate in consumer or advocacy activities related to school and early intervention practice on an individual, community, state, or national basis.	X	X	X	X	X	X

COTAs in early intervention and school settings. These descriptions were adapted from the AOTA documents, "Occupational Therapy Roles" (1993) and *Developing, Maintaining, and Updating Competency in Occupational Therapy: A Guide to Self-Appraisal* (1995b), so OT practitioners can use the roles as a method of monitoring their own role. The roles are meant to be generic, not exclusive.

"Occupational Therapy Roles" describes entry, intermediate, and advanced levels of expertise among practitioners:

- Entry level covers the development of OT skills; acceptance of responsibilities and accountability is expected.
- Intermediate level covers increased independence, mastery of basic role functions, ability to respond to situations while using previous experience, and participation in the education of personnel.
- Advanced level covers refinement of specialized skills and understanding of complex issues that affect role functions.

Note: A practitioner could have skills at various levels and, in fact, could be at all three levels concurrently in different skills.

SUMMARY

The focus of this chapter included two important areas of outcomes: student-specific outcomes and program-specific outcomes. The student-specific outcomes were presented within the service delivery process. Screening/referral, evaluation, development of individualized program/plan, frequency and duration of services, intervention, and documentation were discussed and visual tables provided. Program-specific outcomes focused on accountability, effectiveness of therapy intervention, and documentation. A description of the roles of occupational therapy practitioners in early intervention, preschools, and schools provided readers with a detailed view of skills related to the occupational therapist and the COTA.

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CHECKLIST OF QUESTIONS

1. Can you plot your current workload and responsibilities on a monthly calendar, leaving time for lunch? Do you routinely share a copy of your schedule with your supervisor and communicate methods that you are using for effective service delivery?
2. Which documentation do you find most difficult to complete (for example, assessment, progress notes)? List three ways you could format your notes to make this task more efficient.
3. Does your agency or department develop annual or 3-year plans? If so, do you have a chance for input? If not, could you encourage the development of 3-year goals by using annual objectives to promote more effective practices?

appendices

Appendix A. AOTA Resources

Appendix B. Sample Forms

Appendix C. Official Documents of the American Occupational Therapy Association, Inc.

1. Occupational Therapy Code of Ethics
2. Core Values and Attitudes of Occupational Therapy Practice
3. Standards of Practice for Occupational Therapy
4. Occupational Therapy Services in Early Intervention and Preschool Services
5. Occupational Therapy: A Profession in Support of Full Inclusion
6. White Paper: The Role of the Occupational Therapy Practitioner in the Implementation of Full Inclusion
7. Occupational Performance: Occupational Therapy's Definition of Function
8. Use of Occupational Therapy Aides in Occupational Therapy Practice
9. The Philosophical Base of Occupational Therapy
10. The Psychosocial Core of Occupational Therapy
11. Guide for Supervision of Occupational Therapy Personnel
12. Elements of Clinical Documentation (Revision)
13. Uniform Terminology for Occupational Therapy—Third Edition
14. Knowledge and Skills for Occupational Therapy Practice in the Neonatal Intensive Care Unit
15. Service Delivery in Occupational Therapy

Appendix A—AOTA Resources

Publications

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Self-Study Courses

Assistive Technology and Occupational Therapy: A Link to Function.

Classroom Applications for School-Based Practice.

Cognitive Rehabilitation.

The Practice of the Future: Putting Occupation Back Into Therapy.

School-Based Practice for Related Services.

Appendix B—Sample Forms

Assessment of the Environment

Context Area	Expected Performance in this Context	Skills Needed (Task Analysis)	Supporting Aspects of Environment	Interfering Features of Environment	Plan (Person Responsible/Action)

Source: Taken from the Iowa Guidelines for Educationally Related Occupational Therapy Services. Reprinted with permission by the Iowa Department of Education, Bureau of Special Education.

Occupational Therapy Entrance and Exit Criteria Form

	PERFORMANCE AREAS											
	Activities of Daily Living				Educational & Work Activities					Play or Leisure Activities		
Student's Name: _____ Birth Date: _____ Therapist: _____ Entrance Date: _____ Review Date: _____	Feeding and eating	Dressing	Hygiene	Other:	Utilizing educational materials	Functional communication	Mobility/Transitions	Socialization	Other:	Planning and participating in activities:_____	Utilizing toys, games or equipment	Other:
ENTRANCE CRITERIA: (See directions on back)												
1. Problem significantly interferes with student's ability to participate in his/her educational program.												
2. Problem appears to be caused by limitations in occupational performance component(s).												
3. Previous attempts to alleviate the problem have not been successful, as documented.												
4. Potential for change in student's problem through intervention appears likely (change unrelated to maturity).												
5. Unique expertise of therapist is required to meet student's identified needs.												
Note: Star areas which have met ALL five criteria. These indicate areas which qualify for intervention.												
EXIT CRITERIA: (See directions on back)												
1. Goals or outcomes requiring occupational therapy have been met and no additional ones are appropriate.												
2. Potential for further change as a result of occupational therapy service appears unlikely.												
3. Problem ceases to be educationally relevant.												
4. Therapy is contraindicated due to medical, psychological or social complications.												
NOTE: Mark areas which meet at least ONE of the above exit criteria. These areas no longer qualify for occupational therapy services. If new problems are identified, update areas which may qualify for intervention.												
This form provides a systematic decision-making process to assist in deciding when occupational therapy services should be recommended to help a student meet his/her IEP goals and objectives (including IFSP outcomes). Entrance criteria should be used following the therapist's evaluation, to identify the student's educational problem area(s). Exit criteria should be used following student reassessment. REFERENCE: Rows: horizontal Columns: vertical												

Source: Taken from the Iowa Guidelines for Educationally Related Occupational Therapy Services. (1996). Reprinted with permission by the Iowa Department of Education, Bureau of Special Education.

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Appendix B (continued)

USE OF ENTRANCE AND EXIT CRITERIA FORM

Rationale

This form for occupational therapy entrance and exit criteria is to be used to assist in the decision-making process of determining the appropriateness of identifying occupational therapy as a support service on a student's IEP. It does not delineate the type or amount of service which would be most appropriate to help the individual benefit from his/her educational program. Those are separate decisions that are made after it is decided that occupational therapy is an indicated service to meet a specific student's goals and objectives. Keep in mind that traditional therapy concerns such as range of motion, strengthening, improving balance, and prevention of contractures may be a means for accomplishing a student's educational goals but are not the goal themselves. Parts of this form will rely on professional judgment following a complete occupational therapy assessment.

Directions:

This is a systematic decision-making process to assist in deciding when OT services are an appropriate resource to help a student meet his/her IEP goals and objectives.

Entrance:

Following the occupational therapist's assessment, the student's educational problem(s) should be identified in the performance areas listed. Indicate educational relevance for every performance area by marking the first row with a "yes" for relevance, "no" if not relevant, or "NA" when it is not an area of concern. Then, for performance areas marked with a "yes," check those additional entrance criteria statements down the column. Star the final row under the Entrance Criteria section if **all** criteria have been met to indicate performance areas to be targeted for intervention. If all five entrance criteria have not been checked, then that area would not qualify for occupational therapy intervention.

Exit:

Following student reassessment, check any exit criteria items that apply to previously identified performance areas. Mark a zero (0) in the last column under the Exit Criteria heading when one or more of the exit criteria have been met to indicate that the performance area is no longer targeted for intervention. If exit criteria are not met, leave the final column blank. If new performance areas are identified during this process, complete a new criteria form updating the performance areas.

Source: Taken from the Iowa Guidelines for Educationally Related Occupational Therapy Services. (1996). Reprinted with permission by the Iowa Department of Education, Bureau of Special Education.

Appendix B (continued)

Factors to Consider When Deciding on Amount of Occupational Therapy Service*

FACTORS	1	2	3	4
Potential to benefit with therapeutic intervention	Student demonstrates minimal potential for change	Student appears to have potential for change but at a slower rate	Student appears to have a significant potential for change	Student appears to have a high potential to improve skills
Critical period of skill acquisition or regression related to development or disability	Not a critical period	Minimally critical period	Critical period	Extremely critical period
Amount of program that can be performed by others in addition to therapist intervention	Program can be carried out safely by others with periodic intervention by therapist	Many activities from the program can be safely performed by others in addition to intervention by therapist	Some activities from the program can be safely performed by others in addition to intervention by therapist	A few activities can be safely performed by others but most of the program requires the expertise of the therapist
Amount of training provided by therapist to others carrying out the program	Teacher, staff and/or parents highly trained to meet student's needs. No additional training needed	Teacher, staff and/or parents trained but some follow-up needed	Teacher, staff and/or parents could be trained to carry out some activities	Teacher, staff and/or parents could carry out some activities with extensive training
Amount problem interferes with educational setting	Environment is accommodating and difficulties are minimal	Environment is accommodating and difficulties are moderately interfering	Environment is accommodating but difficulties are significant	Environment is not accommodating; or environment is accommodating but problems are severe

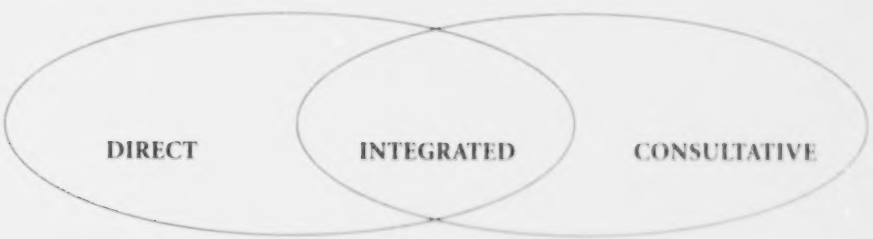
*For complete instructions for utilization of this form, refer to the *Resource Manual for Physical and Occupational Therapists,* 1990 and revisions.

Source: Taken from the Iowa Guidelines for Educationally Related Occupational Therapy Services. (1996). Reprinted with permission by the Iowa Department of Education, Bureau of Special Education.

Appendix B (continued)

Models of Occupational Therapy Service Delivery

	DIRECT	INTEGRATED	CONSULTATIVE
THERAPIST'S PRIMARY CONTACT	• student	• student, teacher, parent, associate	• teacher, parent, associate, student
ENVIRONMENT FOR SERVICE DELIVERY	• distraction-free environment (may need to be separate from learning environment) • specialized equipment needed	• learning environment with support of others within that setting • may include a separate environment at times	• learning environment with support of others within that setting
METHODS OF INTERVENTION	• specific therapeutic techniques which cannot be safely delegated • emphasis on acquisition of new skills	• educationally related functional activities • emphasis on practice of newly acquired motor skills within the daily routine	• educationally related activities • assistive technology • adaptive materials • emphasis on accommodations to learning environment
IMPLEMENTER OF ACTIVITIES	• OT, OTA	• OT, OTA • teacher, parent, associate, other school personnel	• teacher, parent, associate, other school personnel



Source: Taken from the Iowa Guidelines for Educationally Related Occupational Therapy Services. (1996). Reprinted with permission by the Iowa Department of Education, Bureau of Special Education.

Observing Student Performance in School

Student: _____ Age: _____ Date: _____

Observed by: _____

Activity observed: _____

The following questions provide a framework for observing a student in school. The focus of the questions is on behavior and skills that are viewed by educators as essential for successful performance in school.

Performance Parameters	Comments
A Purpose of Task	
1. Academic or nonacademic subject or area?	
2. Objective of lesson/activity?	
3. Relationship to student's IEP goals/objectives?	
B. Nature of Activity	
1. Individual, paired, or group?	
2. Therapeutic domains (motor, perceptual, neuromuscular, sensory processing, adaptive behavior)?	
3. Sensory input inherent in task?	
C. Accuracy of Performance	
1. Which parts of task can student do?	
2. Which parts are difficult?	
3. Does student compensate? How?	
D. Attention to Activity	
1. Length of attention to task?	
2. Distracted? By what stimuli or event?	
3. Can refocus attention if interrupted?	
E. Handling Transitions	
1. From one activity to another?	
2. Within areas of the classroom/school?	
3. Has previous activity affected performance?	

Appendix B (continued)

Performance Parameters	Comments
F. Problem Solving	
1. Understands and follows directions?	
2. Has plan of what to do?	
3. Makes changes if difficulty arises?	
G. Organization	
1. Desk, cubby, backpack (3-D space)?	
2. Papers and workbooks (2-D space)?	
3. Knows schedule and class routines?	
H. Posture/Motor	
1. Comfortable, upright posture for seat work?	
2. Functional self-help and playground skills?	
3. Adequate energy and fatigue levels?	
4. Gets around school environment adequately?	
I. Visual/Motor	
1. Uses age-appropriate grasp (pencils/crayons)?	
2. Uses objects (scissors, erasers) with skill?	
3. Draws/writes legibly with even force and spacing?	
4. Uses dominant/assist hands approriately?	

Impressions:

(Summarize observations, identify any further assessment needed, outline recommendations.)

From *The Consulting Therapist*, by B. E. Hanft and P. Place, 1996, San Antonio, TX: Therapy Skill Builders. Copyright 1996 by Therapy Skill Builders. Reprinted with permission.

Appendix B (continued)

School Consultation Plan

Student's name: _____ Age: _____ Date: _____

Collaborators: _____ Role: _____

_____ Role: _____

_____ Role: _____

1. When and where the consulting therapist will observe/assess/work with the student:

Dates:	Where (classroom, PE, lunch, recess, bathroom, other)?

2. When the consulting therapist will meet with team members for planning:

Dates:	Who? At what time?

3. Student's strengths (observed by educational team and consulting therapist):

4. Student's functional problems (observed by educational team and consulting therapist):

Appendix B (continued)

5. Student's desired educational outcomes (describe desired performance/behavior):

6. Recommendations for intervention:

What to try:	Who will do it?	When?

7 Follow-up plan

How will consulting therapist follow up?	When?

From *The Consulting Therapist*, by B. E. Hanft and P. Place, 1996, San Antonio, TX: Therapy Skill Builders. Copyright 1996 by Therapy Skill Builders. Reprinted with permission.

Appendix B (continued)

Consultant Skills Inventory*

This inventory can help you identify your areas of competence as a consultant as well as pinpoint areas for improvement. Rate your level of skill for each of the items below according to the following scale:

A. *I need to improve this skill.* **B. *I perform this skill adequately.*** **C. *I perform this skill very well.***

Interpersonal Skills	A	B	C
1. I communicated clearly and avoided professional jargon.			
2. I used active listening skills, such as paraphrasing, clarifying, and summarizing, to facilitate the consultation process.			
3. I understood the tasks and responsibilities for each team member.			
4. I elicited team members' observations and viewpoints.			
5. I enabled others to examine their viewpoints of a situation or stated problem and to consider other possible views or explanations.			
6. I managed conflict skillfully and mediated between team members when necessary.			
7. I reinforced and supported the efforts of other team members.			
Collaborative Problem Solving			
1. I identified and clarified problems and needs with team members.			
2. I used a team approach to identify common goals and intervention strategies for the student's educational program.			
3. I used collaborative brainstorming to generate potential solutions to problems and strategies to accomplish objectives.			
4. I integrated feasible alternatives into my consultation plan.			
5. I elicited information to evaluate the effectiveness of the planned educational intervention.			
6. I encouraged the team to reconsider, if necessary, and to change interventions.			
7. I provided information from my own area of expertise without overwhelming others and while acknowledging others' expertise.			
Professional Development			
1. I was able to assess my own effectiveness from the student's progress, parental and staff feedback, and my own self-perceptions.			
2. I requested and accepted feedback and suggestions for improvement.			
3. I sought professional development through conferences, workshops, meetings, or individual study and reading.			

*Adapted with permission from: Klein, S., and S. Kontos. 1993. Best Practices in Integration (BPI) Inservice Training Model. Bloomington, IN: Indiana University.

Notes on my progress and successes:

Goals:

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Appendix C—Official Documents of the American Occupational Therapy Association, Inc.

OCCUPATIONAL THERAPY CODE OF ETHICS

The American Occupational Therapy Association's *Code of Ethics* is a public statement of the values and principles used in promoting and maintaining high standards of behavior in occupational therapy. The American Occupational Therapy Association and its members are committed to furthering people's ability to function within their total environment. To this end, occupational therapy personnel provide services for individuals in any stage of health and illness, to institutions, to other professionals and colleagues, to students, and to the general public.

The Occupational Therapy *Code of Ethics* is a set of principles that applies to occupational therapy personnel at all levels. The roles of practitioner (registered occupational therapist and certified occupational therapy assistant), educator, fieldwork educator, supervisor, administrator, consultant, fieldwork coordinator, faculty program director, researcher/scholar, entrepreneur, student, support staff, and occupational therapy aide are assumed.

Any action that is in violation of the spirit and purpose of this Code shall be considered unethical. To ensure compliance with the Code, enforcement procedures are established and maintained by the Commission on Standards and Ethics. Acceptance of membership in the American Occupational Therapy Association commits members to adherence to the *Code of Ethics* and its enforcement procedures.

Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being of the recipients of their services. (beneficence)

A. Occupational therapy personnel shall provide services in an equitable manner for all individuals.

B. Occupational therapy personnel shall maintain relationships that do not exploit the recipient of services sexually, physically, emotionally, financially, socially or in any other manner. Occupational therapy personnel shall avoid those relationships or activities that interfere with professional judgment and objectivity.

C. Occupational therapy personnel shall take all reasonable precautions to avoid harm to the recipient of services or to his or her property.

D. Occupational therapy personnel shall strive to ensure that fees are fair, reasonable, and commensurate with the service performed and are set with due regard for the service recipient's ability to pay.

Principle 2. Occupational therapy personnel shall respect the rights of the recipients of their services. (e.g., autonomy, privacy, confidentiality)

A. Occupational therapy personnel shall collaborate with service recipients or their surrogate(s) in determining goals and priorities throughout the intervention process.

Appendix C (continued)

B. Occupational therapy personnel shall fully inform the service recipients of the nature, risks, and potential outcomes of any interventions.

C. Occupational therapy personnel shall obtain informed consent from subjects involved in research activities indicating they have been fully advised of the potential risks and outcomes.

D. Occupational therapy personnel shall respect the individual's right to refuse professional services or involvement in research or educational activities.

E. Occupational therapy personnel shall protect the confidential nature of information gained from educational, practice, research, and investigational activities.

Principle 3. Occupational therapy personnel shall achieve and continually maintain high standards of competence. (duties)

A. Occupational therapy practitioners shall hold the appropriate national and state credentials for providing services.

B. Occupational therapy personnel shall use procedures that conform to the Standards of Practice of the American Occupational Therapy Association.

C. Occupational therapy personnel shall take responsibility for maintaining competence by participating in professional development and educational activities.

D. Occupational therapy personnel shall perform their duties on the basis of accurate and current information.

E. Occupational therapy practitioners shall protect service recipients by ensuring that duties assumed by or assigned to other occupational therapy personnel are commensurate with their qualifications and experience.

F. Occupational therapy practitioners shall provide appropriate supervision to individuals for whom the practitioners have supervisory responsibility.

G. Occupational therapists shall refer recipients to other service providers or consult with other service providers when additional knowledge and expertise are required.

Principle 4. Occupational therapy personnel shall comply with laws and Association policies guiding the profession of occupational therapy. (justice)

A. Occupational therapy personnel shall understand and abide by applicable Association policies; local, state, and federal laws; and institutional rules.

B. Occupational therapy personnel shall inform employers, employees, and colleagues about those laws and Association policies that apply to the profession of occupational therapy.

Appendix C (continued)

C. Occupational therapy practitioners shall require those they supervise in occupational therapy related activities to adhere to the *Code of Ethics.*

D. Occupational therapy personnel shall accurately record and report all information related to professional activities.

Principle 5. Occupational therapy personnel shall provide accurate information about occupational therapy services. (veracity)

A. Occupational therapy personnel shall accurately represent their qualifications, education, experience, training, and competence.

B. Occupational therapy personnel shall disclose any affiliations that may pose a conflict of interest.

C. Occupational therapy personnel shall refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, or unfair statements or claims.

Principle 6. Occupational therapy personnel shall treat colleagues and other professionals with fairness, discretion, and integrity. (fidelity, veracity)

A. Occupational therapy personnel shall safeguard confidential information about colleagues and staff.

B. Occupational therapy personnel shall accurately represent the qualifications, views, contributions, and findings of colleagues.

C. Occupational therapy personnel shall report any breaches of the *Code of Ethics* to the appropriate authority.

Author

Commission on Standards and Ethics (SEC)
Ruth Hansen, PhD, OTR, FAOTA, Chairperson

Approved by the Representative Assembly April 1977
Revised 1979, 1988, 1994
Adopted by the Representative Assembly July 1994

Note: This document replaces the *1988 Occupational Therapy Code of Ethics* (*American Journal of Occupational Therapy, 42,* 795-796), which was rescinded by the 1994 Representative Assembly.

Appendix C (continued)

CORE VALUES AND ATTITUDES OF OCCUPATIONAL THERAPY PRACTICE

Introduction

In 1985, the American Occupational Therapy Association (AOTA) funded the Professional and Technical Role Analysis Study (PATRA). This study had two purposes: to delineate the entry-level practice of OTRs and COTAs through a role analysis and to conduct a task inventory of what practitioners actually do. Knowledge, skills, and attitude statements were to be developed to provide a basis for the role analysis. The PATRA study completed the knowledge and skills statements. The Executive Board subsequently charged the Standards and Ethics Commission (SEC) to develop a statement that would describe the attitudes and values that undergird the profession of occupational therapy. The SEC wrote this document for use by AOTA members.

The list of terms used in this statement was originally constructed by the American Association of Colleges of Nursing (AACN) (1986). The PATRA committee analyzed the knowledge statements that the committee had written and selected those terms from the AACN list that best identified the values and attitudes of our profession. This list of terms was then forwarded to SEC by the PATRA Committee to use as the basis for the Core Values and Attitudes paper.

The development of this document is predicated on the assumption that the values of occupational therapy are evident in the official documents of the American Occupational Therapy Association. The official documents that were examined are: (a) *Dictionary Definition of Occupational Therapy* (AOTA, 1986), (b) *The Philosophical Base of Occupational Therapy* (AOTA, 1979), (c) *Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapist* (AOTA, 1991a), (d) *Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapy Assistant* (AOTA, 1991b), and (e) *Occupational Therapy Code of Ethics* (AOTA, 1988). It is further assumed that these documents are representative of the values and beliefs reflected in other occupational therapy literature.

A *value* is defined as a belief or an ideal to which an individual is committed. Values are an important part of the base or foundation of a profession. Ideally, these values are embraced by all members of the profession and are reflected in the members' interactions with those persons receiving services, colleagues, and the society at large. Values have a central role in a profession and are developed and reinforced throughout an individual's life as a student and as a professional.

Actions and attitudes reflect the values of the individual. An attitude is the disposition to respond positively or negatively toward an object, person, concept, or situation. Thus, there is an assumption that all professional actions and interactions are rooted in certain core values and beliefs.

Appendix C (continued)

Seven Core Concepts

In this document, the *core values and attitudes* of occupational therapy are organized around seven basic concepts—altruism, equality, freedom, justice, dignity, truth, and prudence. How these core values and attitudes are expressed and implemented by occupational therapy practitioners may vary depending upon the environments and situations in which professional activity occurs.

Altruism is the unselfish concern for the welfare of others. This concept is reflected in actions and attitudes of commitment, caring, dedication, responsiveness, and understanding.

Equality requires that all individuals be perceived as having the same fundamental human rights and opportunities. This value is demonstrated by an attitude of fairness and impartiality. We believe that we should respect all individuals, keeping in mind that they may have values, beliefs, or life-styles that are different from our own. Equality is practiced in the broad professional arena, but is particularly important in day-to-day interactions with those individuals receiving occupational therapy services.

Freedom allows the individual to exercise choice and to demonstrate independence, initiative, and self-direction. There is a need for all individuals to find a balance between autonomy and societal membership that is reflected in the choice of various patterns of interdependence with the human and nonhuman environment. We believe that individuals are internally and externally motivated toward action in a continuous process of adaptation throughout the life span. Purposeful activity plays a major role in developing and exercising self-direction, initiative, interdependence, and relatedness to the world. Activities verify the individual's ability to adapt, and they establish a satisfying balance between autonomy and societal membership. As professionals, we affirm the freedom of choice for each individual to pursue goals that have personal and social meaning.

Justice places value on the upholding of such moral and legal principles as fairness, equity, truthfulness, and objectivity. This means we aspire to provide occupational therapy services for all individuals who are in need of these services and that we will maintain a goal-directed and objective relationship with all those served. Practitioners must be knowledgeable about and have respect for the legal rights of individuals receiving occupational therapy services. In addition, the occupational therapy practitioner must understand and abide by the local, state, and federal laws governing professional practice.

Dignity emphasizes the importance of valuing the inherent worth and uniqueness of each person. This value is demonstrated by an attitude of empathy and respect for self and others. We believe that each individual is a unique combination of biologic endowment, sociocultural heritage, and life experiences. We view human beings holistically, respecting the unique interaction of the mind, body, and physical and social environment. We believe that dignity is nurtured and grows from the sense of competence and self-worth that is integrally linked to the person's ability to perform valued and relevant activities. In occupational

Appendix C (continued)

therapy we emphasize the importance of dignity by helping the individual build on his or her unique attributes and resources.

Truth requires that we be faithful to facts and reality. Truthfulness or veracity is demonstrated by being accountable, honest, forthright, accurate, and authentic in our attitudes and actions. There is an obligation to be truthful with ourselves, those who receive services, colleagues, and society. One way that this is exhibited is through maintaining and upgrading professional competence. This happens, in part, through an unfaltering commitment to inquiry and learning, to self-understanding, and to the development of an interpersonal competence.

Prudence is the ability to govern and discipline oneself through the use of reason. To be prudent is to value judiciousness, discretion, vigilance, moderation, care, and circumspection in the management of one's affairs, to temper extremes, make judgments, and respond on the basis of intelligent reflection and rational thought.

Summary

Beliefs and values are those intrinsic concepts that underlie the core of the profession and the professional interactions of each practitioner. These values describe the profession's philosophy and provide the basis for defining purpose. The emphasis or priority that is given to each value may change as one's professional career evolves and as the unique characteristics of a situation unfold. This evolution of values is developmental in nature. Although we have basic values that cannot be violated, the degree to which certain values will take priority at a given time is influenced by the specifics of a situation and the environment in which it occurs. In one instance dignity may be a higher priority than truth; in another prudence may be chosen over freedom. As we process information and make decisions, the weight of the values that we hold may change. The practitioner faces dilemmas because of conflicting values and is required to engage in thoughtful deliberation to determine where the priority lies in a given situation.

The challenge for us all is to know our values, be able to make reasoned choices in situations of conflict, and be able to clearly articulate and defend our choices. At the same time, it is important that all members of the profession be committed to a set of common values. This mutual commitment to a set of beliefs and principles that governs our practice can provide a basis for clarifying expectations between the recipient and the provider of services. Shared values empower the profession and, in addition, build trust among ourselves and with others.

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Appendix C (continued)

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Prepared by

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Ruth A. Hansen, PhD, OTR, FAOTA, Chairperson

Approved by the Representative Assembly June 1993

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Appendix C (continued)

STANDARDS OF PRACTICE FOR OCCUPATIONAL THERAPY

Preface

These standards are intended as recommended guidelines to assist occupational therapy practitioners in the provision of occupational therapy services. These standards serve as a minimum standard for occupational therapy practice and are applicable to all individual populations and the programs in which these individuals are served.

These standards apply to those registered occupational therapists and certified occupational therapy assistants who are in compliance with regulation where it exists. The term *occupational therapy practitioner* refers to the registered occupational therapist and to the certified occupational therapy assistant, both of whom are in compliance with regulation where it exists.

The minimum educational requirements for the registered occupational therapist are described in the current *Essentials and Guidelines of an Accredited Educational Program for the Occupational Therapist* (American Occupational Therapy Association [AOTA], 1991a). The minimum educational requirements for the certified occupational therapy assistant are described in the current *Essentials and Guidelines of an Accredited Educational Program for the Occupational Therapy Assistant* (AOTA, 1991b).

Standard I: Professional Standing

1. An occupational therapy practitioner shall maintain a current license, registration, or certification as required by law.
2. An occupational therapy practitioner shall practice and manage occupational therapy programs in accordance with applicable federal and state laws and regulations.
3. An occupational therapy practitioner shall be familiar with and abide by AOTA's (1994) *Occupational Therapy Code of Ethics* (*American Journal of Occupational Therapy, 48,* 1037-1038).
4. An occupational therapy practitioner shall maintain and update professional knowledge, skills, and abilities through appropriate continuing education or in-service training or higher education. The nature and minimum amount of continuing education must be consistent with state law and regulation.
5. A certified occupational therapy assistant must receive supervision from a registered occupational therapist as defined by official AOTA documents. The nature and amount of supervision must be provided in accordance with state law and regulation.
6. An occupational therapy practitioner shall provide direct and indirect services in accordance with AOTA's standards and policies. The nature and scope of occupational therapy services provided must be in accordance with state law and regulation.

Appendix C (continued)

7. An occupational therapy practitioner shall maintain current knowledge of the legislative, political, social, and cultural issues that affect the profession.

Standard II: Referral

1. A registered occupational therapist shall accept referrals in accordance with AOTA's *Statement of Occupational Therapy Referral* (AOTA, 1994) and in compliance with appropriate laws.
2. A registered occupational therapist may accept referrals for assessment or assessment with intervention in performance areas, performance components, or performance contexts when individuals have or appear to have dysfunctions or potential for dysfunctions.
3. A registered occupational therapist, responding to requests for service, may accept cases within the parameters of the law.
4. A registered occupational therapist shall assume responsibility for determining the appropriateness of the scope, frequency, and duration of services within the parameters of the law.
5. A registered occupational therapist shall refer individuals to other appropriate resources when the therapist determines that the knowledge and expertise of other professionals are indicated.
6. An occupational therapy practitioner shall educate current and potential referral sources about the process of initiating occupational therapy referrals.

Standard III: Screening

1. A registered occupational therapist, in accordance with state and federal guidelines, shall conduct screening to determine whether intervention or further assessment is necessary and to identify dysfunctions in performance areas.
2. A registered occupational therapist shall screen independently or as a member of an interdisciplinary team. A certified occupational therapy assistant may contribute to the screening process under the supervision of a registered occupational therapist.
3. A registered occupational therapist shall select screening methods that are appropriate to the individual's age and developmental level; gender; education; cultural background; and socioeconomic, medical, and functional status. Screening methods may include, but are not limited to, interviews, structured observations, informal testing, and record reviews.
4. A registered occupational therapist shall communicate screening results and recommendations to appropriate individuals.

Standard IV: Assessment

1. A registered occupational therapist shall assess an individual's performance areas, performance components, and performance contexts. A registered occupational therapist

Appendix C (continued)

conducts assessments individually or as part of a team of professionals, as appropriate to the practice settings and the purposes of the assessments. A certified occupational therapy assistant may contribute to the assessment process under the supervision of a registered occupational therapist.

2. An occupational therapy practitioner shall educate the individual, or the individual's family or legal guardian, as appropriate, about the purposes and procedures of the occupational therapy assessment.

3. A registered occupational therapist shall select assessments to determine the individual's functional abilities and problems as related to performance areas, performance components, and performance contexts.

4. Occupational therapy assessment methods shall be appropriate to the individual's age and developmental level; gender; education; socioeconomic, cultural, and ethnic background; medical status; and functional abilities. The assessment methods may include some combination of skilled observation, interview, record review, or the use of standardized or criterion-referenced tests. A certified occupational therapy assistant may contribute to the assessment process under the supervision of a registered occupational therapist.

5. An occupational therapy practitioner shall follow accepted protocols when standardized tests are used. Standardized tests are tests whose scores are based on accompanying normative data that may reflect age ranges, gender, ethnic groups, geographic regions, and socioeconomic status. If standardized tests are not available or appropriate, the results shall be expressed in descriptive reports, and standardized scales shall not be used.

6. A registered occupational therapist shall analyze and summarize collected evaluation data to indicate the individual's current functional status.

7. A registered occupational therapist shall document assessment results in the individual's records, noting the specific evaluation methods and tools used.

8. A registered occupational therapist shall complete and document results of occupational therapy assessments within the time frames established by practice settings, government agencies, accreditation programs, and third-party payers.

9. An occupational therapy practitioner shall communicate assessment results, within the boundaries of client confidentiality, to the appropriate persons.

10. A registered occupational therapist shall refer the individual to the appropriate services or request additional consultations if the results of the assessments indicate areas that require intervention by other professionals.

Standard V: Intervention Plan

1. A registered occupational therapist shall develop and document an intervention plan based on analysis of the occupational therapy assessment data and the individual's

expected outcome after the intervention. A certified occupational therapy assistant may contribute to the intervention plan under the supervision of a registered occupational therapist.

2. The occupational therapy intervention plan shall be stated in goals that are clear, measurable, behavioral, functional, and appropriate to the individual's needs, personal goals, and expected outcome after intervention.

3. The occupational therapy intervention plan shall reflect the philosophical base of occupational therapy (AOTA, 1979) and be consistent with its established principles and concepts of theory and practice. The intervention planning processes shall include

    a. Formulating a list of strengths and weaknesses.
    b. Estimating rehabilitation potential.
    c. Identifying measurable short-term and long-term goals.
    d. Collaborating with the individual, family members, other caregivers, professionals, and community resources.
    e. Selecting the media, methods, environment, and personnel needed to accomplish the intervention goals.
    f. Determining the frequency and duration of occupational therapy services.
    g. Identifying a plan for reevaluation.
    h. Discharge planning.

4. A registered occupational therapist shall prepare and document the intervention plan within the time frames and according to the standards established by the employing practice settings, government agencies, accreditation programs, and third-party payers. The certified occupational therapy assistant may contribute to the formation of the intervention plan under the supervision of the registered occupational therapist.

Standard VI: Intervention

1. An occupational therapy practitioner shall implement a program according to the developed intervention plan. The plan shall be appropriate to the individual's age and developmental level, gender, education, cultural and ethnic background, health status, functional ability, interests and personal goals, and service provision setting. The certified occupational therapy assistant shall implement the intervention under the supervision of a registered occupational therapist.

2. An occupational therapy practitioner shall implement the intervention plan through the use of specified purposeful activities or therapeutic methods to enhance occupational performance and achieve stated goals.

3. An occupational therapy practitioner shall be knowledgeable about relevant research in the practitioner's areas of practice. A registered occupational therapist shall interpret research findings as appropriate for application to the intervention process.

Appendix C (continued)

4. An occupational therapy practitioner shall educate the individual, the individual's family or legal guardian, non-certified occupational therapy personnel, and non-occupational therapy staff, as appropriate, in activities that support the established intervention plan. An occupational therapy practitioner shall communicate the risk and benefit of the intervention.
5. An occupational therapy practitioner shall maintain current information on community resources relevant to the practice area of the practitioner.
6. A registered occupational therapist shall periodically reassess and document the individual's levels of functioning and changes in levels of functioning in the performance areas, performance components, and performance contexts. A certified occupational therapy assistant may contribute to the reassessment process under the supervision of a registered occupational therapist.
7. A registered occupational therapist shall formulate and implement program modifications consistent with changes in the individual's response to the intervention. A certified occupational therapy assistant may contribute to program modifications under the supervision of a registered occupational therapist.
8. An occupational therapy practitioner shall document the occupational therapy services provided, including the frequency and duration of the services within the time frames and according to the standards established by the employing facility, government agencies, accreditation programs, and third-party payers.

Standard VII: Transition Services

1. The occupational therapy practitioner shall provide community-referenced services, as necessary, to identify occupational performance needs related to transition. Transition involves outcome-oriented actions which are coordinated to prepare or facilitate an individual for change, such as from one functional level to another, from one life stage to another, from one program to another, or from one environment to another.
2. The occupational therapy practitioner shall participate, when appropriate, in preparing a formal individualized transition plan based on the individual's needs and shall assist in the fulfillment of life roles (e.g., independent or community living, self-care, care for others, work, play, and leisure) through activities in such a plan.
3. The occupational therapy practitioner shall facilitate the transition process in cooperation with the individual and the multidisciplinary team or other community support systems (including family members), when appropriate. The registered occupational therapist shall initiate referrals to appropriate community agencies to provide needed services (e.g., direct service, consultation, monitoring).
4. The occupational therapy practitioner shall determine the effectiveness of transition programs and the extent to which individuals have achieved desired transition outcomes

(e.g., degree to which the individual is integrated and successful in community living and work environments). This is done in conjunction with the individual and other team members, where appropriate.

Standard VIII: Discontinuation

1. A registered occupational therapist shall discontinue service when the individual has achieved predetermined goals or has achieved maximum benefit from occupational therapy services.
2. A registered occupational therapist, with input from a certified occupational therapy assistant where applicable, shall prepare and implement a discharge plan that is consistent with occupational therapy goals, individual goals, interdisciplinary team goals, family goals, and expected outcomes. The discharge plan shall address appropriate community resources for referral for psychosocial, cultural, and socioeconomic barriers and limitations that may need modification.
3. A registered occupational therapist shall document the changes between the initial and current states of functional ability and deficit in performance areas, performance components, and performance contexts. A certified occupational therapy assistant may contribute to the process under the supervision of a registered occupational therapist.
4. An occupational therapy practitioner shall allow sufficient time for the coordination and effective implementation of the discharge plan.
5. A registered occupational therapist shall document recommendations for follow-up or reevaluation when applicable.

Standard IX: Continuous Quality Improvement

1. An occupational therapy practitioner shall monitor and document the continuous quality improvement of practice, which may include outcomes of services, using predetermined practice criteria reflecting professional consensus, recent developments in research, and specific employing facility standards.
2. An occupational therapy practitioner shall monitor all aspects of individual occupational therapy services for effectiveness and timeliness. If actual care does not meet the prescribed standard, it must be justified by peer review or other appropriate means within the practice setting. Occupational therapy services shall be discontinued when no longer necessary.
3. A registered occupational therapist shall systematically assess the review process of patient care to determine the success or appropriateness of interventions. Certified occupational therapy assistants may contribute to the process in collaboration with the registered occupational therapist.

Appendix C (continued)

Standard X: Management

1. A registered occupational therapist shall provide the management necessary for efficient organization and provision of occupational therapy services.
2. A certified occupational therapy assistant, under the supervision of a registered occupational therapist, may perform the following management functions:
   a. Education of members of other related professions and physicians about occupational therapy.
   b. Participation in (1) orientation, supervision, training, and evaluation of the performance of volunteers and other noncertified occupational therapy personnel, and (2) developing plans to remediate areas of skill deficit in the performance of job duties by volunteers and other noncertified occupational therapy personnel.
   c. Design and periodic review of all aspects of the occupational therapy program to determine its effectiveness, efficiency, and future directions.
   d. Systematic review of the quality of service provided, using criteria established by professional consensus and current research, as well as established standards for state regulation; accreditation; American Occupational Therapy Certification Board (AOTCB) certification; and related laws, policies, guidelines, and regulations.
   e. Incorporation of a fair and equitable system of admission, discharge, and charges for occupational therapy services.
   f. Participation in cross-disciplinary activities to ensure that the total needs of the individual are met.
   g. Provision of support (i.e., space, time, money as feasible) for clinical research or collaborative research when such projects have the approval of the appropriate governing bodies (e.g., institutional review board), and the results of which are deemed potentially beneficial to individuals of occupational therapy services now or in the future.

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Appendix C (continued)

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Appendix C (continued)

OCCUPATIONAL THERAPY SERVICES IN EARLY INTERVENTION AND PRESCHOOL SERVICES

The American Occupational Therapy Association, Inc. (AOTA) presents this paper to define the profession's position regarding the contribution of occupational therapy in the provision of early intervention and preschool services to young children who may be developmentally delayed, disabled, or at-risk for developmental dysfunction. Early intervention includes service provision for infants and toddlers from birth through two years and their families. Preschool services are provided for children aged three through five years.

The AOTA supports a family-focused approach to early intervention and preschool services. When families' needs are successfully addressed, children make more progress as well. Occupational therapy personnel must embrace opportunities to empower families to facilitate their children's growth and development. Occupational therapy helps parents to develop and implement interactional strategies with their children and use effective coping strategies that meet the challenge of care giving and family life. Occupational therapy personnel help parents to find satisfaction in their occupational roles as providers and care givers and to increase their skills in managing the stresses of daily living and child care. Siblings are assisted in their adjustment as interdependent but autonomous family members. A prominent feature of services to infants, toddlers, and preschoolers is the number of transitions that families must face. Programmatic changes—such as movement from the hospital to home based services, from home to infant or preschool services, and from preschool to school-aged services—carry with them financial and psychological adjustments as well. Occupational therapy personnel, along with other professionals, are responsible for establishing community collaboration to make these transitions successful experiences for children and families. Occupational therapy personnel who work with young children and their families are responsible not only for providing standard practices generally accepted by the professional community, but also for striving to provide "best practice." Best practice is at the forefront of knowledge and challenges current practices in an effort to more clearly delineate successful strategies that will optimize outcomes. Best practice enables professionals and families to consider unique options that might best fit family needs while continuing to protect the health and safety of the individual. Best practice is always accompanied by thorough documentation of procedures and outcomes so that effectiveness can be established.

Since young children frequently display patterns of behavior that only suggest, but do not define, future status, different intervention approaches are required. In addition to the traditional remediation approach which works to improve areas of difficulty, both compensatory and prevention-intervention models are utilized. Compensatory intervention is used when a problem cannot be substantially changed, regardless of how early the intervention process begins, and supports children's efforts to develop independent skills by minimizing the effect of a problem. Prevention-intervention addresses children who are at-risk for develop-

ing problems but who have not as yet demonstrated delays. Prevention-intervention is a practice approach that establishes an enriched and meaningful environment for these children in an attempt to decrease the long-term effects of risk factors. Occupational therapy personnel support all these approaches with young children as means to increase independence and minimize the effect of delay or disability.

Occupational therapy programs offer carefully designed activities to expand functional capabilities and coping behaviors that enable a child to be an active learner. Enriched sensory and motor experiences serve as a foundation for acquiring high-level function and behavioral competencies within the context of daily living. Eating, playing, moving, and interacting with others are purposeful activities for young children and are vital in the young child's development. These integrative behaviors reflect the organization of sensorimotor, cognitive, and psychosocial skills. Occupational therapists structure activities and adapt the environment in a manner that facilitates learning of these and other skills within natural, goal-directed contexts. When these purposeful activities are effective, they lead to increased independence and a sense of mastery and self-worth. Fundamental to the practice of occupational therapy is its use of self-initiated, purposeful activity to promote adaptive behavior to cope with an ever-changing environment.

In summary, occupational therapy supports the concepts of family-centered approaches, best practice, and professional collaboration in the provision of early intervention and preschool services. Occupational therapy personnel encourage the development of functional skills by utilizing prevention-intervention and remediation. Through environmental adaptations, occupational therapy personnel support compensatory strategies to increase independence.

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Appendix C (continued)

OCCUPATIONAL THERAPY: A PROFESSION IN SUPPORT OF FULL INCLUSION

Full inclusion means that all individuals, regardless of ethnicity, race, age, religion, gender, sexual orientation, or disability, should be able to be a part of the naturally occurring activities of society. Full inclusion addresses the need for all individuals to have the same opportunities. It also recognizes the benefits to everyone of being with individuals who are different from themselves.

Occupational therapy supports full inclusion throughout all practice areas of the profession. Occupational therapy practitioners provide adaptive and compensatory strategies to increase an individual's performance in activities of daily living, work, play, or leisure. Interventions include the use of activities designed to improve performance, as well as the identification of adaptive equipment, environmental modifications, and alternative methods necessary to support improved function. Occupational therapy practitioners assume a collaborative partnership with persons served and their significant others to support the individual's rights to self-direction. Also, occupational therapy practitioners work collaboratively with other professionals to help ensure access to interventions and services in support of full inclusion.

Occupational therapy advocates that society has an obligation to provide reasonable accommodations necessary to allow individuals to access social, vocational, educational, and recreational opportunities. By embracing an attitude of full inclusion, all individuals will benefit from the opportunities afforded by a diverse society.

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Note: To be distributed in conjunction with the white paper entitled, *The Role of the Occupational Therapy Practitioner in the Implementation of Full Inclusion.*

Appendix C (continued)

WHITE PAPER: THE ROLE OF THE OCCUPATIONAL THERAPY PRACTITIONER IN THE IMPLEMENTATION OF FULL INCLUSION

The American Occupational Therapy Association has adopted a position in support of full inclusion, confirming the profession's belief that all persons deserve equal opportunity to participate in society's daily activities (AOTA, in press). This paper is intended to clarify the concept of full inclusion as it applies to occupational therapy practitioners working in a variety of settings with infants, children, and adults with disabilities. In addition, it advocates roles for occupational therapy practitioners as we support full inclusion in practice.

Inclusive environments enable persons with disabilities to belong and participate in varied activities, engaging in meaningful interactions from which they derive self-satisfaction (Grady, 1995). Full inclusion addresses an individual's inherent right to participate in an accepting and supportive society and the creation of opportunities which realize that goal (Stainback et al., 1994). The objective of full inclusion is not simply to move individuals with disabilities to a non-specialized place or location, such as the general education classroom in a neighborhood school. Nor does it focus on the placement of all persons with disabilities in any given environment without accommodations or supportive services as the ultimate goal.

The ideals that are espoused in an inclusive community relate to many of the basic tenets of occupational therapy. The profession's founding principles are based upon belief in human dignity and equality. Further, individual choice and participation in meaningful activity are primary human needs that lead to essential feelings of self-direction and belonging (AOTA, 1993). The promotion of independence in daily life tasks across environments has been valued and embraced throughout the profession's evolution.

As occupational therapy practitioners strive to implement full inclusion into reality, we maintain a commitment to the profession's core body of knowledge and skills gained through entry-level preparation. We recognize and accept the need for professional development and experience leading to competency in working with human diversities in a variety of environments and cultures.The components and characteristics of inclusion discussed in this paper help define the concept and provide the basis for the occupational therapy practitioner's role in its implementation. Full inclusion addresses both human and non-human elements of access and support in society. However, beyond merely integrating people and services into any activities or environments, the concept of full inclusion also incorporates perceptions, values, attitudes, expectations, and behaviors of all persons, those with and without disabilities.

Recognizing and accepting differences is essential as we approach the goal of inclusive environments which promote human diversity and individual choice, rather than creating segregated communities based on homogeneity. Individuals with differing abilities may require accommodation and/or support services in order to exercise their right to belong

Appendix C (continued)

and participate in environments of their choice. Accordingly, the belief in full inclusion requires an accompanying commitment to those accommodations, strategies, and services which may be necessary to promote individuals' access to desired environments, and subsequently, to enable and sustain their performance.

Full inclusion requires contribution and participation from many parties. The individual seeking services, their family and/or caregiver(s), medical and health care professionals, education and social service providers, legislators, business and community members, and others may work together to achieve full inclusion in any given situation. Recognizing the importance of self-direction in the human experience, occupational therapy practitioners encourage individuals with disabilities and their families to fully participate in decision-making that concerns their work, play or leisure, self-help, and other daily life roles. We believe that the consumer perspective is a vital component of the therapeutic process to be respected and incorporated into mutually agreed-upon actions and strategies.

Building inclusive environments provides an opportunity to create meaningful connections between occupational therapy practice and a variety of activities and events, both for the benefit of consumers who seek these services and for society as a whole. Occupational therapy practitioners are dedicated to a team approach which utilizes nondiscriminatory evaluations and includes all relevant viewpoints so that recommendations are made on an individual basis. We encourage the use of innovative and flexible plans that may be required to address new and unique situations. The occupational therapy profession supports accountability in all aspects of service delivery and promotes inquiry and research to document outcomes of inclusion efforts.

Members of the occupational therapy profession advocate inclusive placement and program decisions which are made with careful consideration of the nature and extent of incremental steps and supports needed to realize inclusion's ultimate goal. These supportive efforts may be directed to both human and non-human elements. They include remedial and compensatory interventions and approaches, the use of adaptive equipment, and environmental and activity adaptations, all available in a variety of settings and locations. As this assistance may come from multiple sources, occupational therapy practitioners collaborate with others to identify and provide the supports and services which enable an individual's participation in chosen life tasks across desired environments.

Continual reevaluation of performance, of progress, and of the individual's continuing needs and desires is essential in the creation and maintenance of inclusive communities and environments. These concerns become especially critical during transition in the life span, such as a child's advancement from home to school, a young adult's entry into the work world, or a mature adult's progression from work to retirement.

Occupational therapy practitioners offer consultation to families, caregivers and others, and to the system itself, in order to secure an individual's right to participation and to enable performance within the chosen environment. This consultation may be related to a need for

information, the development of specific skills, adaption of the social or physical environment, or other supportive interventions.

In summary, full inclusion is compatible with the philosophies and ideals of occupational therapy. The implementation of full inclusion challenges occupational therapy practitioners. It offers opportunities for members of the profession and benefits for all society as well. As the diversity of human existence is recognized and differences are embraced through interaction and interdependence, all individuals have an opportunity to expand perceptions, expectations, and understanding.

Now, and into the next century, we anticipate societal challenges related to changing views of health, technological advances, and the implications of disability in an increasingly complex environment (Yerxa, 1994). In response, the occupational therapy profession is poised to accept the responsibility to provide choices, equal opportunities, and benefits for persons with disabilities. The profession supports inclusion efforts for all persons to encourage the removal of physical, legal, and attitudinal barriers to opportunities within society and to improve an individual's ability to realize his or her potential and achieve self-satisfaction.

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Appendix C (continued)

OCCUPATIONAL PERFORMANCE: OCCUPATIONAL THERAPY'S DEFINITION OF FUNCTION

Fidler and Fidler (1963) define function as *doing*; Trombly (1993) promotes the use of *occupational function*; and function can describe a performance (i.e., functional strength, functional range of motion, and functional skills). The word *function* can mean role, use, activity, capacity, job, position, pursuit, or place (Landau & Bogus, 1977). The many ways in which the word *function* is used, or implied, may contribute to confusion regarding occupational therapy's unique role in addressing function. Although there may be some confusion about the use of terms, there is no confusion about the sense of purpose held by occupational therapy practitioners as they address the functional needs of the clients they serve.

Occupational therapy uses the word *function* interchangeably with performance and occupational performance because occupational therapy's domain is the function of the person in his or her occupational roles. The concept of function is implicit, rather than explicit, in many of the frames of reference used by occupational therapy practitioners as they focus on strategies to overcome deficits that impair the function of the individual. Occupational therapy practitioners help people address challenges or difficulties that threaten or impair their ability to perform activities and tasks that are basic to the fulfillment of their roles as worker, parent, spouse or partner, sibling, and friend to self or others.

In order to understand how occupational therapy uses *function*, it is necessary to review the historical roots of occupational therapy. Occupational therapy emerged as a developing profession in the years during and following World War I. The theoretical writings of Adolph Meyer (1922) and others were initially influenced by the then emerging school of American psychology whose "functional approach" focused on the process of adaptation to the environment rather than to the structure of the organism (Boring, 1950). The founders of occupational therapy were committed to the importance of occupation and the preservation of function (Peloquin, 1991), and early clinical efforts focused on the role of work and productivity to maintain or improve function (Hopkins, 1988). The concept of function and occupation remains at the core of occupational therapy today. However, more recently, the interaction of the functional and structural approaches has emerged, and function is viewed as the interaction of neural and physiological mechanisms, behavior, and environment. This interaction is critical to understanding the effect of occupation on health (Almli, 1993), as the function of the individual is supported in a dynamic relationship between the person, his or her occupation, and the environment (see Figure 1). The unique term used by occupational therapists to express function is *occupational performance*. "Occupational performance reflects the individual's dynamic experience of engaging in daily occupations within the environment" (Law & Baum, 1994, p.12).

The concept of function has always been a central focus of occupational therapy and remains so. Other professions are beginning to recognize its importance and are placing increased value on function. Fisher (1992) acknowledged that the common goal of promot-

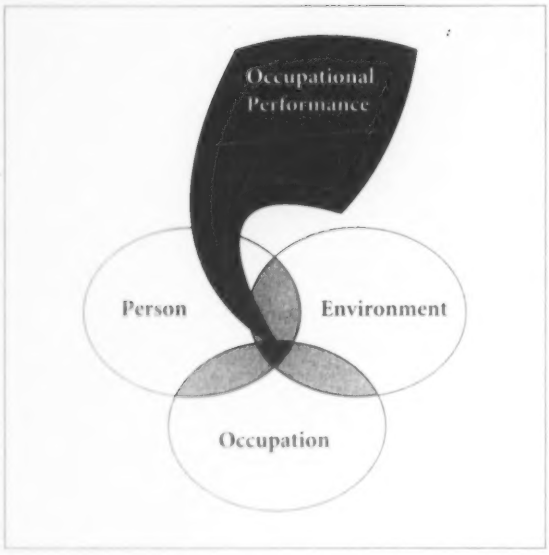

Figure 1. Reprinted with permission from Law, M. (1993). *Planning for children with physical disabilities: Identifying and changing disabling environments through participatory research.* Doctoral dissertation, University of Waterloo, Waterloo, Canada.

ing functional independence is shared by occupational therapy, physical therapy, nursing, social work, psychology, and medicine, among others. A shift is occurring from a focus on pathology to a focus on function as one of the primary indicators of treatment effectiveness (Ware, 1993). This shift also brings to the forefront the issues that occupational therapy has always valued—the person's capacity to function in a community context.

Occupational therapy's emphasis on function is broader than the function of a human organ [or body part] (Christiansen, 1991). It goes far beyond the loss or abnormality of the anatomical structure or function as defined by *impairment* (NCMRR, 1993); or the lack of ability to perform an action or activity in the manner considered normal as defined by *functional limitation* (NCMRR). Occupational therapy views the individual as performing activities and roles within a social, cultural, and physical environment as defined by ability, or with a limitation—*disability* (NCMRR). The occupational therapy practitioner addresses the function of the individual at the occupational performance level where the environmental supports and barriers, the individual's skills, and the individual's occupational demands interact (see Figure 2).

Since 1917, occupational therapy has focused its services to enhance the function of individuals with, or threatened with, disability. Its practitioners have focused their efforts on func-

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Figure 2. Reprinted with permission from Law, M., Cooper, B., Letts, L., Rigby, P., Stewart, S., & Strong, S. (1994). *A model of person-environment interactions: Application to occupational therapy.* Unpublished manuscript, McMaster University, Hamilton, Canada.

tion by using interventions to improve the occupational performance of persons who lack the ability to perform an action or activity considered necessary for their everyday lives. This is accomplished through a joint effort of the person and the clinician, where the person's problems, strengths, and assets are identified; followed by therapeutic interventions, educational strategies, access to resources, and environmental adaptations, so the person can accomplish his or her goals (Law & Baum, 1994). The unique contribution of occupational therapy is that the practitioner creates the opportunity for individuals to gain the skill and confidence to accomplish activities and tasks that are meaningful and productive, and in doing so, increases their occupational performance, thus their function.

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USE OF OCCUPATIONAL THERAPY AIDES IN OCCUPATIONAL THERAPY PRACTICE

The American Occupational Therapy Association, Inc. (AOTA) maintains that consumers must be assured of the availability and accessibility of high quality cost-effective occupational therapy services. This can be facilitated by the appropriate use of occupational therapy aides, thus ensuring greater efficiency and more cost-effective utilization of services provided by the occupational therapy practitioner. An occupational therapy aide is an individual assigned by an occupational therapy practitioner to perform delegated, selected, skilled tasks in specific situations under the intense close supervision of an occupational therapy practitioner. This paper discusses and clarifies the circumstances under which occupational therapists and occupational therapy assistants appropriately use occupational therapy aides. The use of aides raises issues of accountability, supervision, and reimbursement, as well as legal and ethical considerations.

The use of aides as a means to achieve optimal service utilization and contain costs is consistent with the broader trends in health care. In recent years, legislative and regulatory bodies and many health professions have been consistently more attentive to the influence of the use of aides on the quality, utilization, and cost of services. These aides are being used with greater frequency by occupational therapy practitioners in various practice arenas as a result of the need to provide more efficient and cost-effective services, to meet the increasing demand for occupational therapy services, to address a lack of manpower to meet current service demands, and to deal with a geographical maldistribution of existing practitioner resources.

Definitions Specific to the Use of Aides

Occupational therapy practitioner means an individual who is a graduate of an accredited occupational therapy program, is certified by the American Occupational Therapy Certification Board (AOTCB) as an occupational therapist (OTR) or an occupational therapy assistant (COTA), and meets state licensure, certification, or similar requirements, as appropriate.

Skilled tasks means components of specified purposeful activities or therapeutic methods used to achieve intervention goals (AOTA, 1994b, p. 1041).

Occupational therapy aide means an individual assigned by an occupational therapy practitioner to perform delegated, selected, skilled tasks in specific situations under the direction and intense close supervision of an occupational therapy practitioner.

Intense close supervision means daily direct on-site contact.

Supervisory Relationship

The occupational therapist is ultimately responsible and accountable for the overall use of aides to implement tasks in the course of providing occupational therapy services. It is the

occupational therapist alone, or in collaboration with the occupational therapy assistant, who provides the professional judgment of an occupational therapy practitioner in designing, directing, and modifying the plan of treatment and services provided. Appropriate delegation and intense close supervision of tasks are necessary when using aides. The occupational therapist alone, or in collaboration with the occupational therapy assistant, is responsible for providing the initial training and guidance, as well as for exercising ongoing intense close supervision in the course of accomplishing the delegated tasks. The intensity of this supervision is determined by the nature of the task to be performed, the needs of the consumer, and the capability of the aide. The occupational therapy practitioner is responsible and accountable for the overall services provided to the consumer.

The OTR evaluates and directs the focus of interventions to be performed by the COTA under the supervision of the OTR. Where allowable by law or regulation, the OTR or COTA may delegate tasks to an aide and thereby assume responsibility for intense close supervision of the aide. Each occupational therapy practitioner involved in the use of aides is accountable for his or her own actions. However, when a COTA delegates tasks or supervises aide tasks, the supervising OTR maintains overall responsibility for the actions of the aide.

Responsibility/Accountability

The occupational therapy profession is accountable for the quality of occupational therapy services provided to the consumer. These responsibilities include developing policies and procedures for occupational therapy intervention and for establishing the standards of practice (AOTA, 1994b) for occupational therapy services. The *Occupational Therapy Code of Ethics* (AOTA, 1994a) defines the principles necessary for promoting and maintaining the highest standards of ethical behavior. Occupational therapy practitioners shall take personal responsibility for functioning within the ethical code and standards of the profession.

The OTR and COTA are responsible and accountable in all situations for their individual occupational therapy roles and responsibilities, as skilled practitioners from the time of referral to and discharge from occupational therapy services. When aides are used, the occupational therapy practitioner provides intense close supervision of the performance of all delegated tasks and establishes a specific plan of duties as well as the appropriate reporting relationships. These criteria shall be made explicit in workplace policies and procedures. The occupational therapist alone, or in collaboration with the occupational therapy assistant, has a legal and ethical responsibility to delegate to aides only those tasks that are appropriate to the aides' level of training and that can be safely performed and supervised. While employers, administrators, and other professionals may suggest those selected tasks that may be performed by aides, it is the occupational therapy practitioner who shall ultimately make this decision and who is accountable for the delegation of selected tasks to aides in a specific situation. While the occupational therapy practitioner is responsible to the employer for employment activities, the practitioner is also legally accountable to the

Appendix C (continued)

occupational therapy state regulatory board, and all applicable state and federal laws and regulations. The occupational therapy practitioner is also responsible to the employer for external standards in which a service delivery site may choose to participate. Workplace administrative pressures or a shortage of occupational therapy practitioners shall not result in the inappropriate use of aides.

Statutory Requirements

Fifty-two jurisdictions (49 states, the District of Columbia, Guam, and Puerto Rico) regulate occupational therapy through either practice or title acts. State occupational therapy boards, where they exist, are mandated by the legislature and have the responsibility for statutory implementation and regulation of the profession. The use of aides by occupational therapy practitioners shall be in accordance with state law and regulation and shall not infringe on the legal scope of practice of occupational therapy.

Aides are most commonly recognized in state laws and regulations by definition, by supervision requirements, or under exemptions to the law if the aide is employed by or working under the direct supervision of an occupational therapy practitioner. If state law or regulation does not specifically address the use of aides, occupational therapy practitioners should seek guidance on the legal use of aides from the state board regulating occupational therapy.

Most jurisdictions do not specify which tasks can be performed by aides, allowing that determination to be made by the occupational therapy practitioner. Disciplinary action against the occupational therapy practitioner may occur if the practitioner does not ensure that the aide performs only appropriate tasks in a safe and effective manner. In jurisdictions with licensure or practice acts, the delegation or supervision of occupational therapy tasks by unregulated individuals constitutes the unlawful practice of occupational therapy. In jurisdictions with title acts, violations of the law by unregulated persons occur if they represent themselves as providing occupational therapy tasks without the appropriate supervision by an occupational therapy practitioner who meets the qualifications under the title act.

Site-Specific Training

The aide receives site-specific training and should have an understanding of the intent of occupational therapy intervention. The aide shall complete a well-defined and documented training program that ensures that the occupational therapy practitioner is providing quality services when using aides. The training shall focus on site-specific tasks, with an emphasis on the limitations in the role and functions of the aide. The aide, under the direction and intense close supervision of an occupational therapy practitioner, performs only delegated, selected, skilled tasks in specific situations. The process to determine which skilled tasks to delegate to the occupational therapy aide requires the continued professional judgment of the occupational therapy practitioner. Therefore, the aide has no need for professional or advanced training to perform the delegated job duties.

Reimbursement

Reimbursement for occupational therapy service shall be sought only in accordance with existing laws, regulations, and guidelines of third-party payers. Thus, occupational therapy practitioners shall document appropriate use of aides and tasks the aides are performing, so that no false, fraudulent, deceptive, or unfair statements or claims are made.

The federal Medicare program views the occupational therapist as the responsible party in the delivery of occupational therapy services. If aides are utilized without the requisite supervision, however, Medicare would not consider the service to be occupational therapy. Consequently, billing for occupational therapy in this case would be fraudulent. According to interpretation by the Health Care Financing Administration (HCFA), state law supersedes Medicare policy when it is more restrictive or demands more stringent qualifications. For example, in circumstances where occupational therapy state law does not recognize services by aides as occupational therapy, billing for tasks performed by an aide as occupational therapy would not be appropriate, even if the therapist fulfills Medicare's supervision requirements. In practice settings where Medicare policy is silent on the issue of aides, Medicare defers to state law and standards of practice for rules on the use of aides.

Conclusion

The aide, under the direction and intense close supervision of an occupational therapy practitioner, performs only delegated, selected, skilled tasks in specific situations. The process to determine which skilled tasks to delegate to the occupational therapy aide requires the continued professional judgment of the occupational therapy practitioner. Therefore, the aide has no need for professional or advanced training to perform the delegated job duties. The occupational therapy practitioner uses aides to implement tasks in the course of providing occupational therapy services. It is the occupational therapy practitioner, not the aide, who exercises professional judgment in designing and modifying the services.

Aides shall only perform those skilled tasks that do not require:

1) the exercise of the professional judgment of an occupational therapist;

2) the interpretation of referrals, screening, assessment, evaluation, or reassessment;

3) the development or modification of treatment plans; or

4) discharge planning.

Optimal utilization of the OTR and COTA is paramount to the containment of costs and efficient delivery of services. The appropriate, safe, and effective use of occupational therapy aides can serve to increase the productivity of both the OTR and COTA. Thus, proper delegation of tasks to aides can result in greater efficiency and more cost-effective utilization of the occupational therapy practitioner under certain circumstances. Occupational therapy practitioners have a legal and ethical responsibility to delegate to aides only those tasks that can be performed safely and effectively supervised.

Appendix C (continued)

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Approved by the Executive Board as a White Paper March 1994

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Notes

- The *Occupational Therapy Aides White Paper* was approved by the Executive Board in March 1994. This document was further refined during the process of being prepared for the 1995 Representative Assembly as a position paper. While the two documents are essentially the same, there have been specific word refinements and content reorganization in an effort to provide membership with the most up-to-date and concise thinking on this topic. Therefore, the Executive Board rescinded the original white paper at its January 1995 meeting and adopted the final draft of the position paper dated December 1994 as an interim white paper. This draft of the position paper was used as an interim white paper until its adoption as an official document of the Association at the 1995 Representative Assembly.

Appendix C (continued)

- As per adoption of Motion 25MTG2 by the 1995 Representative Assembly, this document will always be accompanied by *The Philosophical Base of Occupational Therapy* (AOTA Policy 1.11) and the official document entitled, *Guide for Supervision of Occupational Therapy Personnel* [See Section VIII. Guidelines].

Appendix C (continued)

THE PHILOSOPHICAL BASE OF OCCUPATIONAL THERAPY

Man is an active being whose development is influenced by the use of purposeful activity. Using their capacity for intrinsic motivation, human beings are able to influence their physical and mental health and their social and physical environment through purposeful activity. Human life includes a process of continuous adaptation. Adaptation is a change in function that promotes survival and self-actualization. Biological, psychological, and environmental factors may interrupt the adaptation process at any time throughout the life cycle. Dysfunction may occur when adaptation is impaired. Purposeful activity facilitates the adaptive process.

Occupational therapy is based on the belief that purposeful activity (occupation), including its interpersonal and environmental components, may be used to prevent and mediate dysfunction, and to elicit maximum adaptation. Activity as used by the occupational therapist includes both an intrinsic and a therapeutic purpose.

This statement was adopted by the April 1979 Representative Assembly of the American Occupational Therapy Association, Inc. as Resolution C #53-79. The text can be found as noted below:

American Occupational Therapy Association (1979). The philosophical base of occupational therapy. *American Journal of Occupational Therapy, 33,* 785.

American Occupational Therapy Association (1979). Policy 1.11. The philosophical base of occupational therapy. In *Policy Manual of The American Occupational Therapy Association, Inc.* Bethesda, MD: Author.

Appendix C (continued)

THE PSYCHOSOCIAL CORE OF OCCUPATIONAL THERAPY

Central to the study and practice of occupational therapy are those concepts and principles that attest to the inexorable union of body and mind and to the inherent significance of purposeful activity (occupational performance) in the quest for health, self-actualization, and social efficacy (Christiansen, 1991; AOTA, 1979). Occupational therapy has historically viewed human performance from a broad, holistic perspective. The doctrine of Moral Treatment in the late 17th and early 18th centuries employed many of the beliefs and concepts that became the foundation of occupational therapy. This philosophy of humane treatment was built on a set of beliefs attesting to the value of human relationships, the importance of a pleasant, humane environment, and the value of daily purposeful activity.

From its inception, occupational therapy has viewed the human being as a complex mix of internal physical, psychologic, social, and cultural variables living within an equally dynamic environmental mixture of social, cultural, interpersonal, economic, and political variables (Kielhofner, 1985). Human performance, the ability "to do," has come to be understood from this perspective. Any intervention, any restorative or rehabilitative effort acknowledged as occupational therapy, must address and skillfully accommodate the interrelatedness of these internal and external variables for each unique individual (Fidler & Fidler, 1983).

The profession has continued to develop from a deeply rooted belief in the critical importance of "doing," of active engagement in purposeful activity as a catalyst in the development of self, and in fulfillment of social membership. This conviction is supported by the concept that the innate human drive to explore and master the environment is essential to human existence and adaptation, not only to assure survival, but to enable the process of humanization. Such a process can be understood as motivation toward achieving a sense of competence, self-reliance, social role learning, and societal contribution.

Occupational therapy seeks to engage an individual's motivation to undertake those activities that minimize disability, encourage compensating behaviors, and/or establish a new activity repertoire to fulfill basic personal needs and meet social role requirements. A fundamental principle that underlies this goal is that an individual's motivation is triggered and sustained when there is a congruence between the characteristics of an activity and the bio-psycho-social characteristics of the person (Fidler, 1981).

Seen from these perspectives, the psychosocial dimensions of the discipline become clearly evident. To speak of independence, competency, self-development, motivation, social membership, and the like, is to accept and respond to the construct that says what touches the body touches the mind, and what touches the mind affects the body. The efficacy of occupational therapy intervention is measured by its considered inclusion of these principles and beliefs, regardless of the nature or acuteness of a disability (Yerxa, 1967).

These psychosocial concepts and postulates are addressed in the developing science on which occupational therapy is based. This evolving body of knowledge seeks to explain how purposeful activity (occupational performance) relates to physical integrity, psychologic structure, social relatedness, and the cultural meanings of activities (Fidler, 1988). Such

Appendix C (continued)

study also investigates how these interrelationships may generate and sustain the motivation and ability to cope with and manage relevant roles and activities of living in ways that are more satisfying than not to self and significant others (Fidler, 1981).

Any injury, illness, or disability elicits a variety of psychosocial responses on the part of the individual and that person's family. Such reactions may be characterized, for example, by a hindering lack of motivation, refusal to participate, an expressed sense of hopelessness, anger, or denial. Although such psychologic reactions are secondary symptoms related to a physical or mental disability and not the primary diagnosis, they must be understood and dealt with by the occupational therapy practitioner if intervention goals are to be achieved. Understanding the complex psychosocial dimensions of human performance, knowing which activities can best be expected to elicit the desired adaptive response, and the artful skill of enabling a trusting, reciprocal relationship, are integral aspects of all occupational therapy practice. Likewise, an appreciation for and accommodation of the impact of the family's psychosocial reactions on the individual is a significant aspect that must shape any occupational therapy intervention.

The therapeutic use of self characterizes the interpersonal dynamic of a helping relationship and is therefore an essential feature of a professional skills repertoire (Mosey, 1986; Peloquin, 1989). The importance of this skill extends well beyond the parameters of the therapeutic dyad. The development and display of an interpersonal competence is a significant component in team membership, collaboration, collegial engagement, family relationships, supervision, teaching, and mentoring. Interpersonal competence is a crucial variable in the occupational therapy practitioner's role of agent for growth and change in self and others.

The psychosocial dimensions of human performance are acknowledged as fundamental in all aspects of occupational therapy, whether practice occurs in settings such as the classroom, rehabilitation center, hospital, nursing home, or community. Such perspectives comprise the context within which occupational therapy practitioners view and address the dynamics of individual performance. These are the psychological and sociologic foundations from which all occupational therapy specialization develops and matures.

There is a difference between the psychosocial foundations of occupational therapy and the specialty of mental health practice. Like other areas of specialization, mental health practice is grounded in the psychosocial core concepts of the profession; but, like other specialties in occupational therapy, it reaches beyond this core to develop a specialized knowledge and expertise that is applicable to a particular population or disability.

Thus, mental health as a specialty practice in occupational therapy is the application of both core and specialized knowledge to those individuals with a diagnosis of mental illness. This area of expertise encompasses knowledge of how psychopathologies (e.g., faulty perceptions, aversions to interpersonal encounters, cognitive dysfunctions, pathologic affective states, or aberrant social behavior) impact the ability to cope with and manage daily living roles and activities. It includes the skillful application of occupational therapy principles, procedures, and interpersonal processes to assess, remediate, and/or compensate for the disabilities of a mental illness and to enable a more satisfying level of performance (Mosey, 1986). These

processes call upon a specialized knowledge and skill of engaging the individual with a mental illness in selected individual and group activities that can be expected to have a remedial effect on given psychopathologies and at the same time be congruent with those activities of daily living that are relevant to that person's lifestyle.

Occupational therapy is a profession committed to making it possible for individuals to attain a way of living that gains for them and for those with whom they share living, a sense of satisfaction, achievement, and contribution. This mission requires vigorous pursuit of the development and refinement of knowledge about the multidimensional aspects of human occupation, the crucial meanings and roles of purposeful activity, and the skillful application of such knowledge. This endeavor thus includes a continuing incentive to reach a sophisticated appreciation of the psychodynamics of human performance and an artful skill in interpersonal engagement. These goals can be realized to the extent that a holistic understanding of the human being is a viable concept guiding the profession's study and daily practice.

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Appendix C (continued)

GUIDE FOR SUPERVISION OF OCCUPATIONAL THERAPY PERSONNEL

The intent of this document is to clarify the supervisory relationships and responsibilities between registered occupational therapists, certified occupational therapy assistants, and other personnel involved in the provision of occupational therapy services. Supervision is a process in which two or more people participate in a joint effort to promote, establish, maintain, and/or elevate a level of performance and service. Supervision is a mutual undertaking between the supervisor and the supervisee that fosters growth and development; assures appropriate utilization of training and potential; encourages creativity and innovation; and provides guidance, support, encouragement, and respect while working toward a goal. As described here, supervision helps promote quality occupational therapy and fosters professional development of the individuals involved.

The American Occupational Therapy Association (AOTA) holds and maintains the principle that those persons not trained and qualified as occupational therapy practitioners (*occupational therapy practitioners* refers to both registered occupational therapists and certified occupational therapy assistants) are not acceptable to supervise occupational therapy practice. It is recognized that occupational therapy practitioners may be administratively supervised by others, such as principals, facility administrators, or physicians. During the supervision of occupational therapy practice, it is the supervisor who is responsible for setting, encouraging, and evaluating the standard of work performed by the supervisee. The amount of supervision required varies, depending upon the occupational therapy practitioner's clinical experience, responsibilities, and level of expertise. Supervision occurs along a continuum that includes close, routine, general, and minimal.

- *Close supervision* requires daily, direct contact at the site of work.
- *Routine supervision* requires direct contact at least every 2 weeks at the site of work, with interim supervision occurring by other methods, such as telephonic or written communication.
- *General supervision* requires at least monthly direct contact, with supervision available as needed by other methods.
- *Minimal supervision* is provided only on a need basis, and may be less than monthly. (AOTA, 1993a, p. 1088)

The amount, degree, and pattern of supervision a practitioner requires varies depending on the employment setting, method of service provision, the practitioner's competence, and the demands of service (i.e., facility standards, state laws and regulations, diagnoses served, techniques used). The method of supervision is determined by the supervising registered occupational therapist. The method should be the one most suitable to the situation. Methods of supervision should be determined before the individual enters into a supervisor–supervisee relationship and should be reevaluated regularly for effectiveness. In all

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Table 1

Identification and Background Information

Content	Clarification
1. Name, age, sex, date of admission, treatment diagnosis, and date of onset of current diagnosis	Name may be omitted, depending on facility and department policies and procedures
2. Referral source, services requested, and date of referral to occupational therapy	Who requested occupational therapy services, what specific services were requested, and date services were requested
3. Medical history and secondary problems or preexisting conditions, prior therapy	Additional problems or conditions that may affect consumer function or outcomes
4. Precautions and contraindications	May be identified by referral source or occupational therapy practitioners
5. Pertinent history that indicates prior levels of function and support systems	Applicable developmental, educational, vocational, cultural, and socioeconomic history
6. Present levels of function in performance areas determined by examination[A]	Brief description of the consumer's level of performance in activities of daily living, work and productive activities, and play or leisure activities
7. Performance contexts determined by examination[A]	Description of those temporal aspects (chronological, developmental, life cycle, health status) and environmental (physical, social, cultural) features that affect the consumer's function in performance areas
8. Consumer and family expectations	Brief description of expected outcome of occupational therapy intervention

[A]Refer to *Uniform Terminology for Occupational Therapy, Third Edition* (AOTA, 1994a), for specific performance areas, performance components, and performance contexts.

Appendix C (continued)

cases, it is the occupational therapy practitioner's ethical responsibility to ensure that the amount, degree, and pattern of supervision are consistent with the level of role performance. As changes in the practice situation occur, the intensity of required supervision may also change to reflect new demands.

The registered occupational therapist has the ultimate responsibility for service provision. By virtue of their education and training, registered occupational therapists are able to provide services independently. Nevertheless, AOTA recommends that entry-level registered occupational therapists receive close supervision and that intermediate-level registered occupational therapists receive routine or general supervision. Certified occupational therapy assistants at all levels require at least general supervision by a registered occupational therapist. The level of supervision is related to the ability of the certified occupational therapy assistant to safely and effectively provide those interventions delegated by a registered occupational therapist. Typically, entry-level certified occupational therapy assistants and certified occupational therapy assistants new to a particular practice environment will require close supervision, intermediate-level practitioners routine supervision, and advanced-level practitioners general supervision. When occupational therapy aides are delegated selected, routine tasks in specific situations, they must work under the close supervision of an occupational therapy practitioner.

These supervision guidelines are to assist occupational therapy practitioners in the provision of occupational therapy services [See Table 1]. The guidelines themselves cannot be interpreted to constitute a standard of supervision in any particular locality; rather, they indicate ideal patterns and types of supervision. All practitioners are expected to meet state and federal regulatory mandates, adhere to relevant Association policies regarding supervision standards, and participate in continuing professional developments.

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Appendix C (continued)

Prepared by

Commission on Practice
Jim Hinojosa, PhD, OTR, FAOTA, Chairperson

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This replaces the 1981 document, *Guide for Supervision of Occupational Therapy Personnel* (*American Journal of Occupational Therapy, 35,* 815–816), which was rescinded by the 1994 Representative Assembly.

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Appendix C (continued)

ELEMENTS OF CLINICAL DOCUMENTATION (REVISION)

These elements are provided to assist occupational therapy practitioners to document occupational therapy services. Occupational therapy practitioners determine the appropriate type of documentation and document the services provided within the time frames established by facilities, government agencies, and accreditation organizations. These elements do not address the specific content of documentation which is unique to occupational therapy intervention for particular ages and types of impairments.

The purpose of documentation is to:

1. Provide a chronological record of the consumer's condition which details the complete course of therapeutic intervention.
2. Facilitate communication among professionals who contribute to the consumer's care.
3. Provide an objective basis to determine the appropriateness, effectiveness, and necessity of therapeutic intervention.
4. Reflect the practitioner's reasoning.

Types of Documentation

I. Evaluation Report

- A. Identification and Background Information
- B. Assessment Results
- C. Intervention or Treatment Plan

II. Contact, Treatment, or Visit Note

III. Progress Report

IV. Re-evaluation Report

V. Discharge or Discontinuation Report

Appendix C (continued)

I. Evaluation Report

Used to document the initial contact with the consumer, the data collected, the interpretation of the data, and the intervention plan. When an abbreviated evaluation process is used, such as screening, it is documented using only limited content areas applicable to the consumer and situation.

A. Identification and Background Information (see Table 1)

B. Assessment Results (see Table 2)

C. Intervention or Treatment Plan (see Table 3)

Table 1

Identification and Background Information

Content	Clarification
1. Name, age, sex, date of admission, treatment diagnosis, and date of onset of current diagnosis	Name may be omitted, depending on facility and department policies and procedures
2. Referral source, services requested, and date of referral to occupational therapy	Who requested occupational therapy services, what specific services were requested, and date services were requested
3. Medical history and secondary problems or preexisting conditions, prior therapy	Additional problems or conditions that may affect consumer function or outcomes
4. Precautions and contraindications	May be identified by referral source or occupational therapy practitioners
5. Pertinent history that indicates prior levels of function and support systems	Applicable developmental, educational, vocational, cultural, and socioeconomic history
6. Present levels of function in performance areas determined by examination[A]	Brief description of the consumer's level of performance in activities of daily living, work and productive activities, and play or leisure activities
7. Performance contexts determined by examination[A]	Description of those temporal aspects (chronological, developmental, life cycle, health status) and environmental (physical, social, cultural) features that affect the consumer's function in performance areas
8. Consumer and family expectations	Brief description of expected outcome of occupational therapy intervention

[A]Refer to *Uniform Terminology for Occupational Therapy, Third Edition* (AOTA, 1994a) for specific performance areas, performance components, and performance contexts.

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Appendix C (continued)

Table 2

Assessment Results	
Content	**Clarification**
1. Tests and assessments administered and the results	Name and type of assessment or test and the results; may include comparison with previous testing. State if standardized procedure not followed.
2. References to other pertinent reports and information	Any additional sources of data or assessment results used.
3. Summary and analysis of evaluation findings	State the type and severity of impairments identified and the functional limitations caused by the impairments in objective, functional, and measurable terms. Include the functional diagnosis.
4. Projected functional outcome(s)	Prognosis and anticipated level of performance (activities of daily [ADL], work or productive activities, and play or leisure activities) the consumer will be able to achieve as a result of therapeutic intervention. May include a statement indicating the consumer does not have the potential to improve beyond current status.

Appendix C (continued)

Table 3

Intervention or Treatment Plan

Content	Clarification
1. Long-term functional goals	Functional limitations that must change in order to achieve the projected functional outcome. Degree the functional limitations will be decreased. Rationale for decreasing functional limitations. Functional change to occur by end of intervention. Consumer and/or family agreement with goals.
2. Short-term goals	Directly relate to long-term functional goals. Impairment that must change in order to achieve the projected functional outcome. Degree the impairment will be decreased. Functional ability that will result from a decrease in level of impairment. Change to occur in a brief period of time (e.g., 7, 14, or 30 days). Consumer and/or family agreement with goals.
3. Intervention or treatment procedures	Activities, techniques, and modalities selected to be used and how they relate to goals. May include family training and home programs. Identify assistive/adaptive equipment, orthotics, and/or prosthetics to meet consumer's environmental adaptation needs.
4. Type, amount, frequency, and duration of intervention or treatment	State skill and performance areas to be addressed and estimate the number, duration, and frequency of sessions to accomplish goals.
5. Recommendations	Need for OT services and necessary referrals to other professionals.

Appendix C (continued)

II. Contact, Treatment, or Visit Note

Used to document individual occupational therapy session or care coordination. May be very brief, such as in the use of a checklist, flow chart, or short narrative type notation (see Table 4).

Table 4

Contact, Treatment, or Visit Note	
1. Attendance and participation	Therapy occurrence or reason for therapy not occurring as scheduled.
2. Activities, techniques, and modalities used	May be indicated by checklist or brief statement.
3. Assistive/adaptive equipment, prosthetics, and orthotics if issued or fabricated, and specific instructions for the application and/or use of the item	State the device; note whether it was fabricated, sold, rented, or loaned; and state the effectiveness of the device.
4. Consumer's response to therapy	Level of performance and anything unusual or significant that was a result of occupational therapy intervention.

Appendix C (continued)

III. Progress Report

Used periodically to document care coordination, interventions, progress toward functional goals, and to update goals and intervention or treatment plan (see Table 5).

Table 5

Progress Report

Content	Clarification
1. Activities, techniques, and modalities used	Brief statement of intervention process.
2. Consumer's response to therapy, and the progress toward short- and long-term goal attainment and comparison with previous functional status	State the consumer's physical and behavioral response to therapy, whether the goals are being achieved, if change has occurred, and how much change has occurred.
3. Goal continuance	Explanation for no or slow progress, reason for not meeting short-term goal(s), or need to continue current goal(s).
4. Goal modification when indicated by the response to therapy or by the establishment of new consumer needs	State new goals and rationale for changes or additions.
5. Change in anticipated time to achieve goals	If, for any reason, the therapy time frame is altered, include the reason for the change and the new anticipated time frame.
6. Assistive/adaptive equipment, prosthetics, and orthotics, if issued or fabricated, and specific instructions for the application and/or use of the item	State the device; note whether it was fabricated, sold, rented, or loaned; and state the effectiveness of the device.
7. Consumer-related conferences and communication	If occupational therapy practitioners participated in a conference or made a pertinent contact with a family member, agency, or health care professional, state this information with a brief summary of the conference or communication.
8. Home programs	Include a copy of the home program as established with the consumer. Include a statement regarding the consumer's ability to follow the program.
9. Consumer/caretaker instruction	What instruction was provided and in what format (i.e., verbal or written).
10. Plan	Specific procedures, communication, or consultations to be done in the future to address the goals.

Appendix C (continued)

IV. Reevaluation Report

Used to document sessions in which portions of the evaluation process are repeated or readministered. Usually occurs monthly or quarterly, depending on the setting (see Table 6).

Table 6

Re-evaluation Report

1. Tests and assessments readministered and the results	Name and type of test readministered. State if standardized procedure is not followed.
2. Comparative summary and analysis of previous evaluation findings	Results analyzed and compared with previous testing.
3. Reestablishment of projected functional outcome(s)	Anticipated level of performance (ADL, work or productive activities, and play or leisure activities) the consumer will be able to achieve as a result of therapeutic intervention. May include a statement of changes in previously established functional outcome(s) based on revised potential or goals of consumer.
4. Update of intervention or treatment plan	Revised or continued long-term functional goals; short-term goals; treatment procedures; and type, amount, and frequency of therapy.

Appendix C (continued)

V. Discharge or Discontinuation Report

Used to document a summary of the course of therapy and any recommendations (see Table 7).

Table 7

Discharge or Discontinuation Report

Content	Clarification
1. Therapy process	Summary of interventions used, consumer's responses, and number of sessions.
2. Goal attainment	Degree to which short- and long-term functional goals were achieved.
3. Functional outcome	Comparison of functional status prior to therapy and at discharge.
4. Home programs	Include the actual written home program that is to be followed after discharge.
5. Follow-up plans	State the schedule and specific plans.
6. Recommendations	State any recommendations pertaining to the consumer's future needs.
7. Referral(s) to other health care providers and community agencies	Indicate referral(s) or recommendations for referral(s) when additional or new services are needed.

Fundamental Elements of Documentation

Each consumer of occupational therapy services must have a case record maintained as a permanent file. The record should be organized, legible, concise, clear, accurate, complete, current, and objective. Correct grammar and spelling should be used.

The following 10 elements should be present:

1. Consumer's full name and case number on each page of documentation.
2. Date stated as month, day, and year for each entry; time of intervention; and length of session.
3. Identification of type of documentation and department name.
4. Practitioner's signature with a minimum of first name or initial, last name, and professional designation.
5. Signature of the recorder directly at the end of the note without space left between the body of the note and the signature.
6. Countersignature by a registered occupational therapist (OTR) on documentation written by students and certified occupational therapy assistants (COTA) when required by law or the facility.

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7. Compliance with confidentiality standards.
8. Acceptable terminology as defined by the facility.
9. Facility-approved abbreviations.
10. Errors corrected by drawing a single line through an error, and the correction initialed (liquid correction fluid and erasures are not acceptable), or facility requirements followed.

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This document replaces the 1986 *Guidelines for Occupational Therapy Documentation. (American Journal of Occupational Therapy, 40,* 830–832).

Note. If a document is revised, the previous version is superseded and, according to Parliamentary procedure, is automatically rescinded.

Appendix C (continued)

UNIFORM TERMINOLOGY FOR OCCUPATIONAL THERAPY—THIRD EDITION

This is an official document of the American Occupational Therapy Association. This document is intended to provide a generic outline of the domain of concern of occupational therapy and is designed to create common terminology for the profession and to capture the essence of occupational therapy succinctly for others.

It is recognized that the phenomena that constitute the profession's domain of concern can be categorized, and labeled, in a number of different ways. This document is not meant to limit those in the field, formulating theories or frames of reference, who may wish to combine or refine particular constructs. It is also not meant to limit those who would like to conceptualize the profession's domain of concern in a different manner.

Introduction

The first edition of Uniform Terminology was approved and published in 1979 (AOTA, 1979). In 1989, *Uniform Terminology for Occupational Therapy—Second Edition* (AOTA, 1989) was approved and published. The second document presented an organized structure for understanding the areas of practice for the profession of occupational therapy. The document outlined two domains. **Performance areas** (activities of daily living [ADL], work and productive activities, and play or leisure) include activities that the occupational therapy practitioner emphasizes when determining functional abilities (*occupational therapy practitioner* refers to both registered occupational therapists and certified occupational therapy assistants). **Performance components** (sensorimotor, cognitive, psychosocial, and psychological aspects) are the elements of performance that occupational therapists assess and, when needed, in which they intervene for improved performance.

This third edition has been further expanded to reflect current practice and to incorporate contextual aspects of performance. **Performance areas, performance components,** and **performance contexts** are the parameters of occupational therapy's domain of concern. *Performance areas* are broad categories of human activity that are typically part of daily life. They are activities of daily living, work and productive activities, and play or leisure activities. *Performance components* are fundamental human abilities that—to varying degrees and in differing combinations—are required for successful engagement in performance areas. These components are sensorimotor, cognitive, psychosocial, and psychological. *Performance contexts* are situations or factors that influence an individual's engagement in desired and/or required performance areas. Performance contexts consist of *temporal* aspects (chronological age, developmental age, place in the life cycle, and health status) and *environmental* aspects (physical, social, and cultural considerations). There is an interactive relationship among performance areas, performance components, and performance contexts. Function in performance areas is the ultimate concern of occupational therapy, with performance components considered as they relate to participation in performance areas. Performance areas

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and performance components are always viewed within performance contexts. Performance contexts are taken into consideration when determining function and dysfunction relative to performance areas and performance components, and in planning intervention. For example, the occupational therapist does not evaluate strength (a performance component) in isolation. Strength is considered as it affects necessary or desired tasks (performance areas). If the individual is interested in homemaking, the occupational therapy practitioner would consider the interaction of strength with homemaking tasks. Strengthening could be addressed through kitchen activities, such as cooking and putting groceries away. In some cases, the practitioner would employ an adaptive approach and recommend that the family switch from heavy stoneware to lighter-weight dishes, or use lighter-weight pots on the stove to enable the individual to make dinner safely without becoming fatigued or compromising safety.

Occupational therapy assessment involves examining performance areas, performance components, and performance contexts. Intervention may be directed toward elements of performance areas (e.g., dressing, vocational exploration), performance components (e.g., endurance, problem solving), or the environmental aspects of performance contexts. In the latter case, the physical and/or social environment may be altered or augmented to improve and/or maintain function. After identifying the performance areas the individual wishes or needs to address, the occupational therapist assesses the features of the environments in which the tasks will be performed. If an individual's job requires cooking in a restaurant as opposed to leisure cooking at home, the occupational therapy practitioner faces several challenges to enable the individual's success in different environments. Therefore, the third critical aspect of performance is the performance context, the features of the environment that affect the person's ability to engage in functional activities.

This document categorizes specific activities in each of the performance areas (ADL, work and productive activities, play or leisure). This categorization is based on what is considered "typical," and is not meant to imply that a particular individual characterizes personal activities in the same manner as someone else. Occupational therapy practitioners embrace individual differences, and so would document the unique pattern of the individual being served, rather than forcing the "typical" pattern on him or her and family. For example, because of experience or culture, a particular individual might think of home management as an ADL task rather than "work and productive activities" (current listing). Socialization might be considered part of a play or leisure activity instead of its current listing as part of "activities of daily living," because of life experience or cultural heritage.

Examples of Use in Practice

Uniform Terminology—Third Edition defines occupational therapy's domain of concern, which includes performance areas, performance components, and performance contexts. While this document may be used by occupational therapy practitioners in a number of different areas (e.g., practice, documentation, charge systems, education, program development, m keting, research, disability classifications, and regulations), it focuses on the use of

uniform terminology in practice. This document is not intended to define specific occupational therapy programs or specific occupational therapy interventions. Examples of how performance areas, performance components, and performance contexts translate into practice are provided below.

- An individual who is injured on the job may have the potential to return to work and productive activities, which is a performance area. In order to achieve the outcome of returning to work and productive activities, the individual may need to address specific performance components, such as strength, endurance, soft tissue integrity, time management, and the physical features of performance contexts, like structures and objects in his or her environment. The occupational therapy practitioner, in collaboration with the individual and other members of the vocational team, uses planned interventions to achieve the desired outcome. These interventions may include activities such as an exercise program, body mechanics instruction, and job site modifications, all of which may be provided in a work-hardening program.
- An elderly individual recovering from a cerebrovascular accident may wish to live in a community setting, which combines the performance areas of ADL with work and productive activities. In order to achieve the outcome of community living, the individual may need to address specific performance components, such as muscle tone, gross motor coordination, postural control, and self-management. It is also necessary to consider the sociocultural and physical features of performance contexts, such as support available from other persons, and adaptations of structures and objects within the environment. The occupational therapy practitioner, in cooperation with the team, utilizes planned interventions to achieve the desired outcome. Interventions may include neuromuscular facilitation, practice of object manipulation, and instruction in the use of adaptive equipment and home safety equipment. The practitioner and individual also pursue the selection and training of a personal assistant to ensure the completion of ADL tasks. These interventions may be provided in a comprehensive inpatient rehabilitation unit.
- A child with learning disabilities is required to perform educational activities within a public school setting. Engaging in educational activities is considered the performance area of work and productive activities for this child. To achieve the educational outcome of efficient and effective completion of written classroom work, the child may need to address specific performance components. These include sensory processing, perceptual skills, postural control, motor skills, and the physical features of performance contexts, such as objects (e.g., desk, chair) in the environment. In cooperation with the team, occupational therapy interventions may include activities like adapting the student's seating in the classroom to improve postural control and stability, and practicing motor control and coordination. This program could be developed by an occupational therapist and supported by school district personnel.
- The parents of an infant with cerebral palsy may ask to facilitate the child's involvement in the performance areas of activities of daily living and play. Subsequent to assessment,

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the therapist identifies specific performance components, such as sensory awareness and neuromuscular control. The practitioner also addresses the physical and cultural features of performance contexts. In collaboration with the parents, occupational therapy interventions may include activities such as seating and positioning for play, neuromuscular facilitation techniques to enable eating, facilitating parent skills in caring for and playing with their infant, and modifying the play space for accessibility. These interventions may be provided in a home-based occupational therapy program.

- An adult with schizophrenia may need and want to live independently in the community, which represents the performance areas of activities of daily living, work and productive activities, and leisure activities. The specific performance categories may be medication routine, functional mobility, home management, vocational exploration, play or leisure performance, and social interaction. In order to achieve the outcome of living independently, the individual may need to address specific performance components, such as topographical orientation; memory; categorization; problem solving; interests; social conduct; time management; and sociocultural features of performance contexts, such as social factors (e.g., influence of family and friends) and roles. The occupational therapy practitioner, in cooperation with the team, utilizes planned interventions to achieve the desired outcome. Interventions may include activities such as training in the use of public transportation, instruction in budgeting skills, selection and participation in social activities, instruction in social conduct, and participation in community reintegration activities. These interventions may be provided in a community-based mental health program.
- An individual with a history of substance abuse may need to reestablish family roles and responsibilities, which represent the performance areas of activities of daily living, work and productive activities, and leisure activities. In order to achieve the outcome of family participation, the individual may need to address the performance components of roles; values; social conduct; self-expression; coping skills; self-control; and the sociocultural features of performance contexts, such as custom, behavior, rules, and rituals. The occupational therapy practitioner, in cooperation with the team, utilizes planned interventions to achieve the desired outcomes. Interventions may include roles and values exercises, instruction in stress management techniques, identification of family roles and activities, and support to develop family leisure routines. These interventions may be provided in an inpatient acute care unit.

Person–Activity–Environment Fit

Person–activity–environment fit refers to the match among the skills and abilities of the individual; the demands of the activity; and the characteristics of the physical, social, and cultural environments. It is the interaction among the performance areas, performance components, and performance contexts that is important and determines the success of the performance. When occupational therapy practitioners provide services, they attend to all of these aspects of performance and the interaction among them. They also attend to each

individual's unique personal history. The personal history includes one's skills and abilities (performance components), the past performance of specific life tasks (performance areas), and experience within particular environments (performance contexts). In addition to personal history, anticipated life tasks and role demands influence performance.

When considering the person–activity–environment fit, variables such as novelty, importance, motivation, activity tolerance, and quality are salient. Situations range from those that are completely familiar to those that are novel and have never been experienced. Both the novelty and familiarity within a situation contribute to the overall task performance. In each situation, there is an optimal level of novelty that engages the individual sufficiently and provides enough information to perform the task. When too little novelty is present, the individual may miss cues and opportunities to perform. When too much novelty is present, the individual may become confused and distracted, inhibiting effective task performance.

Humans determine that some stimuli and situations are more meaningful than others. Individuals perform tasks they deem important. It is critical to identify what the individual wants or needs to do when planning interventions.

The level of motivation an individual demonstrates to perform a particular task is determined by both internal and external factors. An individual's biobehavioral state (e.g., amount of rest, arousal, tension) contributes to the potential to be responsive. The features of the social and physical environments (e.g., persons in the room, noise level) provide information that is either adequate or inadequate to produce a motivated state.

Activity tolerance is the individual's ability to sustain a purposeful activity over time. Individuals must not only select, initiate, and terminate activities, but they must also attend to a task for the needed length of time to complete the task and accomplish their goals.

The quality of performance is measured by standards generated by both the individual and others in the social and cultural environments in which the performance occurs. Quality is a continuum of expectations set within particular activities and contexts (see Figure 1).

Uniform Terminology for Occupational Therapy—Third Edition

Occupational therapy is the use of purposeful activity or interventions to promote health and achieve functional outcomes. *Achieving functional outcomes* means to develop, improve, or restore the highest possible level of independence of any individual who is limited by a physical injury or illness, a dysfunctional condition, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or learning disability, or an adverse environmental condition. *Assessment* means the use of skilled observation or evaluation by the administration and interpretation of standardized or nonstandardized tests and measurements to identify areas for occupational therapy services.

Occupational therapy services include, but are not limited to:

1. the assessment, treatment, and education of or consultation with the individual, family, or other persons; or

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2. interventions directed toward developing, improving, or restoring daily living skills, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills;

3. providing for the development, improvement, or restoration of sensorimotor, oral-motor, perceptual or neuromuscular functioning; or emotional, motivational, cognitive, or psychosocial components of performance.

These services may require assessment of the need for and use of interventions such as the design, development, adaptation, application, or training in the use of assistive technology devices; the design, fabrication, or application of rehabilitative technology such as selected orthotic devices; training in the use of assistive technology, orthotic or prosthetic devices; the application of physical agent modalities as an adjunct to or in preparation for purposeful activity; the use of ergonomic principles; the adaptation of environments and processes to enhance functional performance; or the promotion of health and wellness (AOTA, 1993, p. 1117).

I. Performance Areas

Throughout this document, activities have been described as if individuals performed the tasks themselves. Occupational therapy also recognizes that individuals arrange for tasks to be done through others. The profession views independence as the ability to self-determine activity performance, regardless of who actually performs the activity.

A. *Activities of Daily Living*—Self-maintenance tasks.

1. *Grooming*—Obtaining and using supplies; removing body hair (use of razors, tweezers, lotions, etc.); applying and removing cosmetics; washing, drying, combing, styling, and brushing hair; caring for nails (hands and feet), caring for skin, ears, and eyes; and applying deodorant.

2. *Oral Hygiene*—Obtaining and using supplies; cleaning mouth; brushing and flossing teeth; or removing, cleaning, and reinserting dental orthotics and prosthetics.

3. *Bathing/Showering*—Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; and transferring to and from bathing positions.

4. *Toilet Hygiene*—Obtaining and using supplies; clothing management; maintaining toileting position; transferring to and from toileting position; cleaning body; and caring for menstrual and continence needs (including catheters, colostomies, and suppository management).

5. *Personal Device Care*—Cleaning and maintaining personal care items, such as hearing aids, contact lenses, glasses, orthotics, prosthetics, adaptive equipment, and contraceptive and sexual devices.

6. *Dressing*—Selecting clothing and accessories appropriate to time of day, weather, and occasion; obtaining clothing from storage area; dressing and undressing in a sequential

Figure 1

Uniform Terminology for Occupational Therapy Third Edition Outline

I. Performance Areas

A. Activities of Daily Living
- 1. Grooming
- 2. Oral Hygiene
- 3. Bathing/Showering
- 4. Toilet Hygiene
- 5. Personal Device Care
- 6. Dressing
- 7. Feeding and Eating
- 8. Medication Routine
- 9. Health Maintenance
- 10. Socialization
- 11. Functional Communication
- 12. Functional Mobility
- 13. Community Mobility
- 14. Emergency Response
- 15. Sexual Expression

B. Work and Productive Activities
- 1. Home Management
  - a. Clothing Care
  - b. Cleaning
  - c. Meal Preparation/Cleanup
  - d. Shopping
  - e. Money Management
  - f. Household Maintenance
  - g. Safety Procedures
- 2. Care of Others
- 3. Educational Activities
- 4. Vocational Activities
  - a. Vocational Exploration
  - b. Job Acquisition
  - c. Work or Job Performance
  - d. Retirement Planning
  - e. Volunteer Participation

C. Play or Leisure Activities
- 1. Play/Leisure Exploration
- 2. Play/Leisure Performance

II. Performance Components

A. Sensorimotor Component
- 1. Sensory
  - a. Sensory Awareness
  - b. Sensory Processing
    - (1) Tactile
    - (2) Proprioceptive
    - (3) Vestibular
    - (4) Visual
    - (5) Auditory
    - (6) Gustatory
    - (7) Olfactory
  - c. Perceptual Processing
    - (1) Stereognosis
    - (2) Kinesthesia
    - (3) Pain Response
    - (4) Body Scheme
    - (5) Right-Left Discrimination
    - (6) Form Constancy
    - (7) Position in Space
    - (8) Visual-Closure
    - (9) Figure Ground
    - (10) Depth Perception
    - (11) Spatial Relations
    - (12) Topographical Orientation
- 2. Neuromusculoskeletal
  - a. Reflex
  - b. Range of Motion
  - c. Muscle Tone
  - d. Strength
  - e. Endurance
  - f. Postural Control
  - g. Postural Alignment
  - h. Soft Tissue Integrity
- 3. Motor
  - a. Gross Coordination
  - b. Crossing the Midline
  - c. Laterality
  - d. Bilateral Integration
  - e. Motor Control
  - f. Praxis
  - g. Fine Coordination/Dexterity
  - h. Visual-Motor Integration
  - i. Oral-Motor Control

B. Cognitive Integration and Cognitive Components
- 1. Level of Arousal
- 2. Orientation
- 3. Recognition
- 4. Attention Span
- 5. Initiation of Activity
- 6. Termination of Activity
- 7. Memory
- 8. Sequencing
- 9. Categorization
- 10. Concept Formation
- 11. Spatial Operations
- 12. Problem Solving
- 13. Learning
- 14. Generalization

C. Psychosocial Skills and Psychological Components
- 1. Psychological
  - a. Values
  - b. Interests
  - c. Self-Concept
- 2. Social
  - a. Role Performance
  - b. Social Conduct
  - c. Interpersonal Skills
  - d. Self-Expression
- 3. Self-Management
  - a. Coping Skills
  - b. Time Management
  - c. Self-Control

III. Performance Contexts

A. Temporal Aspects
- 1. Chronological
- 2. Developmental
- 3. Life Cycle
- 4. Disability Status

B. Environmental Aspects
- 1. Physical
- 2. Social
- 3. Cultural

Appendix C (continued)

fashion; fastening and adjusting clothing and shoes; and applying and removing personal devices, prostheses, or orthoses.

7. *Feeding and Eating*—Setting up food; selecting and using appropriate utensils and tableware; bringing food or drink to mouth; cleaning face, hands, and clothing; sucking, masticating, coughing, and swallowing; and management of alternative methods of nourishment.

8. *Medication Routine*—Obtaining medication, opening and closing containers, following prescribed schedules, taking correct quantities, reporting problems and adverse effects, and administering correct quantities by using prescribed methods.

9. *Health Maintenance*—Developing and maintaining routines for illness prevention and wellness promotion, such as physical fitness, nutrition, and decreasing health risk behaviors.

10. *Socialization*—Accessing opportunities and interacting with other people in appropriate contextual and cultural ways to meet emotional and physical needs.

11. *Functional Communication*—Using equipment or systems to send and receive information, such as writing equipment, telephones, typewriters, computers, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for the deaf, and augmentative communication systems.

12. *Functional Mobility*—Moving from one position or place to another, such as in-bed mobility, wheelchair mobility, transfers (wheelchair, bed, car, tub, toilet, tub/shower, chair, floor). Performing functional ambulation and transporting objects.

13. *Community Mobility*—Moving self in the community and using public or private transportation, such as driving, or accessing buses, taxi cabs, or other public transportation systems.

14. *Emergency Response*—Recognizing sudden, unexpected hazardous situations, and initiating action to reduce the threat to health and safety.

15. *Sexual Expression*—Engaging in desired sexual and intimate activities.

B. *Work and Productive Activities*—Purposeful activities for self-development, social contribution, and livelihood.

1. *Home Management*—Obtaining and maintaining personal and household possessions and environment.

a. *Clothing Care*—Obtaining and using supplies; sorting, laundering (hand, machine, and dry clean); folding; ironing; storing; and mending.

b. *Cleaning*—Obtaining and using supplies; picking up; putting away; vacuuming; sweeping and mopping floors; dusting; polishing; scrubbing; washing windows; cleaning mirrors; making beds; and removing trash and recyclables.

c. *Meal Preparation and Cleanup*—Planning nutritious meals; preparing and serving food; opening and closing containers, cabinets and drawers; using kitchen utensils and appliances; cleaning up and storing food safely.

d. *Shopping*—Preparing shopping lists (grocery and other); selecting and purchasing items; selecting method of payment; and completing money transactions.

e. *Money Management*—Budgeting, paying bills, and using bank systems.

f. *Household Maintenance*—Maintaining home, yard, garden, appliances, vehicles, and household items.

g. *Safety Procedures*—Knowing and performing preventive and emergency procedures to maintain a safe environment and to prevent injuries.

2. *Care of Others*—Providing for children, spouse, parents, pets, or others, such as giving physical care, nurturing, communicating, and using age-appropriate activities.

3. *Educational Activities*—Participating in a learning environment through school, community, or work-sponsored activities, such as exploring educational interests, attending to instruction, managing assignments, and contributing to group experiences.

4. *Vocational Activities*—Participating in work-related activities.

a. *Vocational Exploration*—Determining aptitudes; developing interests and skills, and selecting appropriate vocational pursuits.

b. *Job Acquisition*—Identifying and selecting work opportunities, and completing application and interview processes.

c. *Work or Job Performance*—Performing job tasks in a timely and effective manner; incorporating necessary work behaviors.

d. *Retirement Planning*—Determining aptitudes; developing interests and skills; and selecting appropriate avocational pursuits.

e. *Volunteer Participation*—Performing unpaid activities for the benefit of selected individuals, groups, or causes.

C. *Play or Leisure Activities*—Intrinsically motivating activities for amusement, relaxation, spontaneous enjoyment, or self-expression.

1. *Play or Leisure Exploration*—Identifying interests, skills, opportunities, and appropriate play or leisure activities.

2. *Play or Leisure Performance*—Planning and participating in play or leisure activities. Maintaining a balance of play or leisure activities with work and productive activities, and activities of daily living. Obtaining, utilizing, and maintaining equipment and supplies.

II. Performance Components

A. *Sensorimotor Component*—The ability to receive input, process information, and produce output.

1. *Sensory*

a. *Sensory Awareness*—Receiving and differentiating sensory stimuli.

Appendix C (continued)

b. *Sensory Processing*—Interpreting sensory stimuli:

(1) *Tactile*—Interpreting light touch, pressure, temperature, pain, and vibration through skin contact/receptors.

(2) *Proprioceptive*—Interpreting stimuli originating in muscles, joints, and other internal tissues that give information about the position of one body part in relation to another.

(3) *Vestibular*—Interpreting stimuli from the inner ear receptors regarding head position and movement.

(4) *Visual*—Interpreting stimuli through the eyes, including peripheral vision and acuity, and awareness of color and pattern.

(5) *Auditory*—Interpreting and localizing sounds, and discriminating background sounds.

(6) *Gustatory*—Interpreting tastes.

(7) *Olfactory*—Interpreting odors.

c. *Perceptual Processing*—Organizing sensory input into meaningful patterns.

(1) *Stereognosis*—Identifying objects through proprioception, cognition, and the sense of touch.

(2) *Kinesthesia*—Identifying the excursion and direction of joint movement.

(3) *Pain Response*—Interpreting noxious stimuli.

(4) *Body Scheme*—Acquiring an internal awareness of the body and the relationship of body parts to each other.

(5) *Right–Left Discrimination*—Differentiating one side from the other.

(6) *Form Constancy*—Recognizing forms and objects as the same in various environments, positions, and sizes.

(7) *Position in Space*—Determining the spatial relationship of figures and objects to self or other forms and objects.

(8) *Visual-Closure*—Identifying forms or objects from incomplete presentations.

(9) *Figure Ground*—Differentiating between foreground and background forms and objects.

(10) *Depth Perception*—Determining the relative distance between objects, figures, or landmarks and the observer, and changes in planes of surfaces.

(11) *Spatial Relations*—Determining the position of objects relative to each other.

(12) *Topographical Orientation*—Determining the location of objects and settings and the route to the location.

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2. *Neuromusculoskeletal*

a. *Reflex*—Eliciting an involuntary muscle response by sensory input.

b. *Range of Motion*—Moving body parts through an arc.

c. *Muscle Tone*—Demonstrating a degree of tension or resistance in a muscle at rest and in response to stretch.

d. *Strength*—Demonstrating a degree of muscle power when movement is resisted, as with objects or gravity.

e. *Endurance*—Sustaining cardiac, pulmonary, and musculoskeletal exertion over time.

f. *Postural Control*—Using righting and equilibrium adjustments to maintain balance during functional movements.

g. *Postural Alignment*—Maintaining biomechanical integrity among body parts.

h. *Soft Tissue Integrity*—Maintaining anatomical and physiological condition of interstitial tissue and skin.

3. *Motor*

a. *Gross Coordination*—Using large muscle groups for controlled, goal-directed movements.

b. *Crossing the Midline*—Moving limbs and eyes across the midsagittal plane of the body.

c. *Laterality*—Using a preferred unilateral body part for activities requiring a high level of skill.

d. *Bilateral Integration*—Coordinating both body sides during activity.

e. *Motor Control*—Using the body in functional and versatile movement patterns.

f. *Praxis*—Conceiving and planning a new motor act in response to an environmental demand.

g. *Fine Coordination/Dexterity*—Using small muscle groups for controlled movements, particularly in object manipulation.

h. *Visual-Motor Integration*—Coordinating the interaction of information from the eyes with body movement during activity.

i. *Oral-Motor Control*—Coordinating oropharyngeal musculature for controlled movements.

B. *Cognitive Integration and Cognitive Components*—The ability to use higher brain functions.

1. *Level of Arousal*—Demonstrating alertness and responsiveness to environmental stimuli.

Appendix C (continued)

2. *Orientation*—Identifying person, place, time, and situation.

3. *Recognition*—Identifying familiar faces, objects, and other previously presented materials.

4. *Attention Span*—Focusing on a task over time.

5. *Initiation of Activity*—Starting a physical or mental activity.

6. *Termination of Activity*—Stopping an activity at an appropriate time.

7. *Memory*—Recalling information after brief or long periods of time.

8. *Sequencing*—Placing information, concepts, and actions in order.

9. *Categorization*—Identifying similarities of and differences among pieces of environmental information

10. *Concept Formation*—Organizing a variety of information to form thoughts and ideas.

11. *Spatial Operations*—Mentally manipulating the position of objects in various relationships.

12. *Problem Solving*—Recognizing a problem, defining a problem, identifying alternative plans, selecting a plan, organizing steps in a plan, implementing a plan, and evaluating the outcome.

13. *Learning*—Acquiring new concepts and behaviors.

14. *Generalization*—Applying previously learned concepts and behaviors to a variety of new situations.

C. *Psychosocial Skills and Psychological Components*—The ability to interact in society and to process emotions.

1. *Psychological*

a. *Values*—Identifying ideas or beliefs that are important to self and others.

b. *Interests*—Identifying mental or physical activities that create pleasure and maintain attention.

c. *Self-Concept*—Developing the value of the physical, emotional, and sexual self.

2. *Social*

a. *Role Performance*—Identifying, maintaining, and balancing functions one assumes or acquires in society (e.g., worker, student, parent, friend, religious participant).

b. *Social Conduct*—Interacting by using manners, personal space, eye contact, gestures, active listening, and self-expression appropriate to one's environment.

Appendix C (continued)

c. *Interpersonal Skills*—Using verbal and nonverbal communication to interact in a variety of settings.

d. *Self-Expression*—Using a variety of styles and skills to express thoughts, feelings, and needs.

3. *Self-Management*

a. *Coping Skills*—Identifying and managing stress and related factors.

b. *Time Management*—Planning and participating in a balance of self-care, work, leisure, and rest activities to promote satisfaction and health.

c. *Self-Control*—Modifying one's own behavior in response to environmental needs, demands, constraints, personal aspirations, and feedback from others.

III. Performance Contexts

Assessment of function in performance areas is greatly influenced by the contexts in which the individual must perform. Occupational therapy practitioners consider performance contexts when determining feasibility and appropriateness of interventions. Occupational therapy practitioners may choose interventions based on an understanding of contexts, or may choose interventions directly aimed at altering the contexts to improve performance.

A. *Temporal Aspects*

1. *Chronological*—Individual's age.

2. *Developmental*—Stage or phase of maturation.

3. *Lifecycle*—Place in important life phases, such as career cycle, parenting cycle, or educational process.

4. *Disability status*—Place in continuum of disability, such as acuteness of injury, chronicity of disability, or terminal nature of illness.

B. *Environment*

1. *Physical*—Nonhuman aspects of contexts. Includes the accessibility to and performance within environments having natural terrain, plants, animals, buildings, furniture, objects, tools, or devices.

2. *Social*—Availability and expectations of significant individuals, such as spouse, friends, and caregivers. Also includes larger social groups which are influential in establishing norms, role expectations, and social routines.

3. *Cultural*—Customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the individual is a member. Includes political aspects, such as laws that affect access to resources and affirm personal rights. Also includes opportunities for education, employment, and economic support.

Appendix C (continued)

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This document replaces the following documents, all of which were rescinded by the 1994 Representative Assembly: *Occupational Therapy Product Output Reporting System* (1979), *Uniform Terminology for Reporting Occupational Therapy Services—First Edition* (1979), "Uniform Occupational Therapy Evaluation Checklist" (1981, *American Journal of Occupational Therapy, 35,* 817–818), and "Uniform Terminology for Occupational Therapy—Second Edition" (1989, *American Journal of Occupational Therapy, 43,* 808–815).

KNOWLEDGE AND SKILLS FOR OCCUPATIONAL THERAPY PRACTICE IN THE NEONATAL INTENSIVE CARE UNIT

Introduction

Occupational therapy with infants in a neonatal intensive care unit (NICU) and their families is a high-risk and specialized area of practice. The characteristics of each infant, family, and hospital environment are unique. For these reasons, the registered occupational therapist requires advanced knowledge and skills to practice in the NICU.

Specialized knowledge of neonatal medical conditions and developmental variability and abnormality in infants cared for in the NICU is essential to safe, effective practice. The therapist must recognize the complex medical needs and vulnerabilities of acutely ill or immature infants. These infants are frequently physiologically fragile and easily compromised by environmental conditions. Interactions and therapeutic interventions that may appear innocuous can trigger physiologic instability in an infant and can be life threatening. Traditional occupational therapy approaches, such as sensory integration or neurodevelopmental treatment, may not be appropriate or may need to be modified according to the infant's medical status and developmental needs.

The unique needs of families whose infants are in the NICU also must be recognized. The infant's medical status and uncertain outcome, the highly technical environment of the NICU, and potential maternal complications after labor and delivery may contribute to family stress or crisis. Families are best served by an occupational therapist who is sensitive to family circumstances, priorities, and concerns, and who is knowledgeable about infant needs. The occupational therapist must seek ways to establish supportive, collaborative, and therapeutic relationships with family members in order to foster the infant's optimal development.

The social and physical aspects of the environment of the NICU significantly impact both the infant and the family. All individuals who interact with the infant comprise the social environment. The physical environment is composed of inanimate elements and properties (e.g., lighting, noise, and equipment). The occupational therapist must understand the interplay of the NICU's social and physical features and the way in which this interplay influences the infant, family, and staff. This knowledge is used as part of the occupational therapy assessment and contributes to effective intervention strategies.

An important role of the occupational therapist is to assist the family in fostering their infant's optimal development, including neurobehavioral organization, sensory and motor processes, and daily life activities, while considering the medical and physiological status of the infant. Through direct treatment, consultation, education, and research, the occupational therapist collaborates with others to improve the fit among infant, parent, and environment.

Occupational therapy philosophy and education provide the foundation for this profession to make a unique and valuable contribution to neonatal practice. Basic occupational therapy

Appendix C (continued)

training provides knowledge of biological sciences, disease processes, mental health, and normal and abnormal child development. Occupational therapy's domain of concern, encompassing the interaction among the biological, developmental, and psychosocial aspects of human function, makes it particularly suited to address the needs of the developing infant and family. The unique occupational therapy method of task analysis and task adaptation to achieve a functional outcome is valuable in improving the fit between the infant and the environment.

Prior experience in pediatric occupational therapy is essential for practice in the NICU. It provides a perspective of the continuum of normal and abnormal child development and of the significance of the family in the child's life. Experience in pediatric occupational therapy affords opportunities for skill development in assessment and intervention to facilitate change in children. Therefore, the therapist interested in practicing in the NICU should have prior experience in the following areas: pediatric occupational therapy with infants and young children, longitudinal follow-up of infants treated in the NICU, and collaboration with families.

The occupational therapist working in the NICU requires specialized knowledge and skills beyond basic occupational therapy education and general pediatric occupational therapy practice. Since practice in the NICU requires advanced knowledge and skills, it is not an appropriate practice area for the certified occupational therapy assistant. This area of practice is also not appropriate for the entry-level therapist or the registered occupational therapist who does not have the pediatric experience described above.

The specialized knowledge required for practice in the NICU includes: familiarity with relevant medical conditions, procedures, and equipment; an understanding of the unique developmental abilities and vulnerabilities of the infant; an understanding of theories of neonatal behavioral organization; family systems; NICU ecology; and the manner in which these factors interact to influence behavior. The occupational therapist develops the necessary skills through supervised clinical experience in assessment and intervention specific to the NICU.

Neonatal practice requires advanced clinical reasoning skills. These skills include flexibility to recognize and respond to unfamiliar situations and nuances of behavior, the ability to sense future directions of treatment, and the ability to perceive the clinical condition as a whole. The occupational therapist in the NICU applies these competencies with regard to the infant, the infant's family, and the NICU environment.

Maintenance of competency is a continuous process and is particularly important in the rapidly changing field of neonatology. Competence must be sustained through regular supervision or a mentoring relationship; participation in peer study groups and continuing education; and ongoing, critical review of the relevant research and literature as this field of practice rapidly changes.

Appendix C (continued)

Knowledge and Skills: The Infant, Family, and NICU Environment

The following description identifies the knowledge and skills needed to function as an occupational therapist in the NICU. This information is organized into the three main areas of occupational therapy concern described previously: the infant, the family, the NICU environment.

The Infant

The competent occupational therapist has an in-depth understanding of approaches to assessment and intervention. These approaches are presented in literature specific to occupational therapy, neonatology, and infant and family studies. In addition, the therapist has a thorough understanding of medical factors and the potential risks they pose to normal fetal and infant growth and development. The therapist understands and critically analyzes this information within the context of occupational therapy practice and the specific philosophy of the NICU in which the occupational therapist functions. The occupational therapist then develops appropriate intervention strategies. For clarity, infant behavior is discussed separately from family and environmental concerns. However, in program implementation, the infant is assessed and treated within the context of the family and the NICU environment.

I. Medical knowledge base as the foundation for understanding infant behavior

A. General information

1. Medical terminology and abbreviations used in the NICU.

2. Basic principles, uses, and potential complications of the medical equipment and procedures, including precautions and implications for the therapist.

3. Medical complications frequently encountered, including pathophysiology, risks, precautions, and prognoses associated with specific conditions.

B. Specific knowledge of:

1. NICU equipment

2. Diagnostic procedures

3. Medical procedures

4. Nursing procedures

5. Respiratory support

6. Thermoregulatory support

7. Nutritional support

8. Medication effects

9. Infection control

10. Institution-specific policies and procedures

Appendix C (continued)

II. Factors that may influence infant and child development

A. Prenatal

1. Maternal and fetal complications during pregnancy
2. Anomalies (e.g., syndromes, associations, sequences, and isolated defects)
3. Teratogens (e.g., drug exposure, TORCH, radiation)

B. Perinatal

1. Maternal complications during delivery
2. Neonatal complications during delivery
3. Gestational age and birthweight

C. Postnatal conditions and complications

1. Respiratory
2. Cardiovascular
3. Neurologic
4. Sensory
5. Orthopedic
6. Gastrointestinal
7. Metabolic
8. Hemolytic
9. Dermatologic
10. Infectious disease

III. Knowledge of the unique developmental course, abilities, and vulnerabilities of infants in the NICU

A. Differences in developmental progression, variations, deviations, and abnormalities in infants in relation to preterm, term, or postterm birth and/or prenatal, perinatal, or postnatal factors

1. Infant neurobehavioral organization

a. Physiologic (e.g., cardiorespiratory)

b. State (e.g., range, clarity, and modulation)

c. Regulatory abilities (e.g., use of self-regulation and external regulation)

d. Neurosocial (e.g., attention and interaction)

Appendix C (continued)

2. Sensory development and processing of sensory information

   a. Systems: tactile, vestibular, proprioceptive, visual, auditory, olfactory, gustatory

   b. Responses: arousal, attention, modulation, transition, optimal range of response

3. Motor function

   a. Neuromotor development, including, but not limited to, muscle tone, posture, movement, reflexes, and motor control

   b. Biomechanical status, including, but not limited to, active and passive range of motion, strength, and orthopedic status

4. Daily life activities

   a. General considerations that influence daily life activities

      (1) Postconceptional age and weight

      (2) Maturation

      (3) Physiological status and medical conditions

      (4) Neurobehavioral organization

      (5) Sensory processing

      (6) Biomechanical and neuromotor function

      (7) Social interaction

      (8) Physical environment

   b. Specific activities

      (1) Feeding

         (a) modes (e.g., breast, bottle, tube)

         (b) function (e.g., duration and volume)

         (c) oral-motor structure and function

         (d) mechanical and neural control of suck, swallow, and respiration

         (e) relationship among feeding, ventilation, and oxygenation

      (2) Sleeping/waking

         (a) diurnal rhythmicity

         (b) normal and abnormal patterns

      (3) Caregiving

Appendix C (continued)

(a) medical routines

(b) bathing, dressing, moving, and carrying

(c) nurturance

B. The interrelationship between medical and developmental domains

IV. Knowledge of evolving developmental approaches in the NICU

A. Historical and current perspectives of:

1. supplemental stimulation

2. reduced stimulation

3. environmental neonatology

4. individualized developmental care

5. family-centered care

B. Modification and integration of current pediatric occupational therapy theories (e.g., sensory integration and neurodevelopmental therapy)

V. Specific skills related to occupational therapy with infants in the NICU. The occupational therapist should be able to:

A. Use NICU equipment appropriately and safely.

B. Conduct appropriate assessments.

1. Determine appropriate timing of infant assessments based on the infant's medical status, postconceptional age, and NICU routines.

2. Select formal and informal assessment methods that:

a. are appropriate for postconceptional age and medical condition

b. identify developmental abilities, vulnerabilities, and abnormalities in the areas of:

(1) neurobehavioral organization

(2) sensory development and processing

(3) motor function

(4) daily life activities

3. Assess the effects of caregiving, positioning, and nurturance on the infant's neurobehavioral organization, sensory, motor, and medical status.

C. Formulate an individualized therapeutic intervention plan that supports the infant's current level of function and facilitates optimal development of the infant.

Appendix C (continued)

1. Determine appropriate timing of infant interventions based on the infant's medical status, postconceptional age, and NICU routines.

2. Use occupational therapy interventions that consider the individual infant's medical and physiological status.

a. Facilitate and support infant neurobehavioral organization.

b. Modulate sensory input that is contingent on infant behaviors.

c. Facilitate neurosocial function.

d. Modify and apply techniques to promote optimal infant neuromotor functioning and engagement in daily life activities.

e. Use biomechanical techniques, such as range of motion, splinting, and positioning as appropriate to promote motor function and engagement in daily life activities.

f. Use techniques to facilitate function in daily life activities.

g. Provide adaptations of infant daily life activities to facilitate well-organized infant behavior.

D. Continuously observe and critically analyze subtle infant responses to the therapeutic program and revise as needed.

E. Collaborate with team members, including the family, to:

1. create and maintain developmental care plans

2. incorporate the occupational therapy program into the NICU routines

F. Provide documentation that is objective, interpretive, thorough, and concise.

G. Formulate discharge and follow-up plans in coordination with the interdisciplinary team and community resources to meet the infant's developmental needs.

Knowledge and Skills: The Family

Parents and other family members are acknowledged to be the most important, consistent influence in the infant's life. Parents are important mediators of the infant's affective, sensory, and motor experiences. The occupational therapist collaborates with family members, on and off-site, to facilitate the infant's optimal development, to promote the parents' occupational roles as caregivers and nurturers, and to ensure a successful transition from hospital to the community.

I. Knowledge of the family as a basis for collaboration

A. Family systems

1. Family structure, occupational roles, cultural identification, beliefs, and practices

Appendix C (continued)

2. Family resources: Sources and allocation; e.g., time, money, energy, and social-emotional support

3. Family adaptation

a. Adjustment to adding a new family member

b. Stressful situations

B. Adult learning styles

1. Individual differences in learning

2. Relationship between emotional state and learning capacities

3. Changes in parental focus during NICU course

C. Parent-infant interactions: Progression and individual differences

1. Parents' role in the infant's early emotional development

2. Attachment, including the influence of hospitalization on the attachment process

3. Development of synchronous interactions

D. The transition of the infant from hospital to community

1. Possible stresses and difficulties inherent in the transition process for both infant and each family member

2. Knowledge of community resources and local, state, and federal guidelines and services

II. Specific skills related to the family

A. Identify family interests, attitudes, knowledge, strengths, priorities, preferred communication style, and skills regarding daily care, play, and other interactions with their infant.

B. Identify family members' learning styles.

C. Guide family members in observing and interpreting their infant's behavior and in adapting their own behaviors:

1. To elicit appropriate sensory, motor, and social responses

2. During daily life activities

D. Foster successful parent-infant interactions vía mutual problem solving, anticipatory guidance, modeling of behaviors, didactic and experiential education, and modification of the hospital environment.

E. Integrate family observations in formulating occupational therapy intervention recommendations.

Appendix C (continued)

F. Interpret occupational therapy assessment findings to the family.

G. Adapt intervention approaches according to families' changing interests, emotions, and needs, which may be influenced by the infant's changing medical status or other non-infant-related issues.

H. Participate in the formulation of a discharge and follow-up plan from the point of initial occupational therapy involvement.

I. Implement a discharge and follow-up plan with the family and other team members to ensure a smooth transition to the community, integrating occupational therapy goals into the overall goals and priorities of the family.

Knowledge and Skills: The Neonatal Intensive Care Unit Environment

The NICU environment influences infant and adult behaviors. Adapting or structuring the environment to provide a therapeutic challenge to elicit behavior change is a well-accepted occupational therapy approach. However, this first requires knowledge of the various components of the environment and their interplay. The occupational therapist assesses the environment and collaborates with other staff to shape the infant's physical and social environment to provide a milieu of developmental care.

I. Knowledge of the unique sensory properties of the NICU and their relationship to neurobehavioral organization

A. Visual: timing, ambient and focal light intensity, contents of visual field

B. Auditory: intensity, duration, timing; animate vs. inanimate

C. Tactile-proprioceptive-vestibular: timing, pressure, texture, handling for medical/nursing procedures, and parent interaction

D. Olfactory and gustatory experiences specific to the NICU

II. Knowledge of the social environment and its relationship to neurobehavioral organization, including interactions and relationships between:

A. Staff-infant

B. Parent-infant

C. Parent-staff

III. Knowledge of the physical environment and its relationship to neurobehavioral organization

A. Medical equipment and procedures as described under the medical knowledge base section

B. Frequency, timing, duration, intensity of sensory input from medical equipment and procedures

Appendix C (continued)

C. Noncontingent input from equipment, procedures, and staff to surrounding infants

IV. Knowledge of the NICU organizational culture

A. NICU specific philosophy of care, including its particular orientation toward acute and chronic care

B. The team members' roles, functions, and positions in the organizational structure of the individual NICU

C. The influence of NICU stressors (e.g., census changes and subsequent staffing patterns)

D. Communication patterns and structure, both formal and informal, among staff and between family and staff

E. Spoken and unspoken rules of behavior

F. The effect of the physical and social environment on staff performance

V. Specific skills in assessing and adapting the environment

A. Assess the sensory aspects of the NICU physical and social environment and its effect on infant behavior.

B. Develop intervention strategies, educate, and collaborate with the NICU team to adapt the environment to foster optimal infant development and family interaction.

1. Communicate with all levels of staff to establish rapport and develop team commitment to developmental and family goals.

2. Integrate occupational therapy goals into the infant's medical priorities and the NICU routines.

C. Develop and implement strategies to influence philosophy and practice of developmental care within the NICU.

D. Assess the effect of intervention strategies and revise the plan accordingly.

Professional and Personal Characteristics Necessary for Occupational Therapists Practicing in the NICU

The NICU, as a critical care area, necessitates certain professional and personal characteristics. These characteristics include an:

1. Ability to synthesize a wide variety of information, including research findings, and judiciously apply it to this clinical setting.

2. Ability to observe the infant and environment for prolonged periods, without intervening, and to identify and understand subtle nuances.

3. Interest in and the ability to bring about changes through:

Appendix C (continued)

a. direct intervention with the infant and family

b. consultation and collaboration with other team members

c. policies and procedures at the organizational level.

4. Understanding of one's interpersonal communication skills and the ability to modify them in response to family and staff behavior.

5. Academic interest in and commitment to seeking ongoing knowledge, education, and research in this field.

6. Ability to provide educational programs to hospital and community personnel.

7. Insight into one's professional skills and limitations.

8. Ability to value, communicate and collaborate with other team members and community resources.

9. Understanding and ability to articulate one's values and attitudes about:

a. the rights and responsibilities of families

b. the influence of cultural and religious beliefs on medical management decisions

c. working with infants who ultimately may not survive

d. working with infants who may have severe and permanent disabilities

e. working with families whose values, attitudes, and life circumstances differ from one's own

f. the appropriation of scarce fiscal, personnel, and technological resources to sustain an infant's life.

Definitions

Clinical Reasoning Skills in Occupational Therapy

The process by which therapists individualize and modify treatment. It includes not only the application of theory to practice, but treatment of the meaning of illness as experienced by the individual and family (Mattingly, 1991).

Environmental Neonatology

The study of environment of newborn special care facilities and its impact on the medical and developmental status of sick infants (Gottfried & Gaiter, 1985).

Family

Composed of individuals who are linked by shared kinship, function, and/or responsibilities and who identify themselves in a common relationship.

Family-Centered Care

A constellation of philosophies, attitudes, and approaches to the care of children with special health and development needs that recognizes that the family is the constant in the

Appendix C (continued)

child's life and that parent-professional partnerships are essential to effective and high-quality service provision (National Center for Family-Centered Care, 1990).

Fit

(Also referred to as "goodness-of-fit")

"The degree to which the properties of its environment are in accord with the organism's own characteristics or style of behaving" (Chess & Birch, 1968).

High-Risk Area of Practice

"Interventions may place the patient at risk of serious consequences or of deprivation of substantial benefit when care is not provided correctly or is not provided when indicated" (Joint Commission on Accreditation of Health Organizations, 1991).

Neurobehavioral Organization

Refers to an interrelationship between what the infant exhibits as behaviors and the degree or type of central nervous system integrity and function. A neurological basis for behavior is implied. Neurobehaviors have been described theoretically as being organized according to clusters, systems, subsystems, etc., that interact to produce relative degrees of behavioral organization/disorganization. One example is the framework proposed by Als in her synactive model. Autonomic, motoric, and state-attentional subsystems are proposed, plus infant capacities for self-regulation and use of regulation provided by the environment (Als, 1982).

Neurosocial

The ability to interact as the nervous system matures in preterm infants. There are three developmental stages of neurosocial development: turning in, coming out, and reciprocity (Gorski, Davidson, & Brazelton, 1979).

NICU

Nurseries are designated as Level I, Level II, or Level III, based on their responsibilities and the availability of special services.

Level I Nursery

For routine, uncomplicated deliveries and neonatal care, unexpected complications must be medically managed until transfer can be arranged to a more sophisticated facility.

Level II Nursery

Personnel and equipment are available to manage uncomplicated deliveries and neonatal care as well as many common problems of high-risk mothers and neonates.

Level III Nursery

Personnel and equipment are available to provide appropriate care to all mothers and infants along the risk spectrum, including the healthy term, preterm, critically ill, and/or malformed infant (Ryan, 1975).

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Physiologic Instability

Refers to a lack of balance or equilibrium within the autonomic nervous system. Signs of physiologic instability may include changes in cardiorespiratory status (heart rate, respiratory rate, decreased oxygen saturation), color changes (pale, dusky, mottled, flushed), or visceral cues (yawning, sneezing, gagging, spitting-up, hiccupping, bowel movement). Conversely, an infant with physiologic stability will be calm with stable color and vital signs (Als, 1986).

Regulatory Abilities

Refers to the infant's capacity to modulate or modify his or her own state of arousal and neurobehavioral organization (Als, 1982).

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SERVICE DELIVERY IN OCCUPATIONAL THERAPY

Purpose

The purpose of this concept paper is to provide the occupational therapy practitioners with a basis for considering and defining occupational therapy service delivery. The American Occupational Therapy Association (AOTA) asserts that service delivery is client-centered and interactive in nature, and that it must be consistent with occupational therapy's philosophical base (AOTA, 1979), core value and beliefs (AOTA, 1993a), principles of theory and practice, and code of ethics (AOTA, 1994a).

Premises

1. Service delivery is client-centered and recognizes the client's needs, wants, and priorities.
2. Service delivery involves the occupational therapy practitioner and client in a collaborative process of working together to design and implement services.
3. Occupational therapy practitioners provide services in many roles and in various settings to meet the needs of clients.
4. A client-centered perspective recognizes that the occupational therapy practitioner's interventions focus on performance in occupational activities (activities of daily living, work and productive activities, play or leisure activities) that meets the needs of the client.
5. Service delivery decisions consider systems, models, and contexts relative to client needs.
6. Service delivery is based on the philosophical base and established principles of occupational therapy theory and practice.
7. Occupational therapy service delivery is consistent with professional standards and ethics and in accordance with federal, state, and local regulations.

Definitions

Client. Refers to a person, group, program, or organization for whom the occupational therapy practitioner is providing services.

Occupational therapy practitioner. An individual who is credentialed as an occupational therapist (OTR) or occupational therapy assistant (COTA) (AOTA, 1994b).

System. An organized entity of interdependent components or principles that provides a structure by which to work or function.

Model. An approach, framework, or structure that organizes knowledge for the purpose of guiding decisionmaking.

Context. This is a critical aspect of performance that affects a person's ability to engage in functional activities. Context includes temporal aspects (chronological, developmental, life cycle, disability status) and environmental aspects (physical, social, cultural) (AOTA, 1994c).

Client-centered service delivery. An interactive approach to service that considers systems, models, and contexts in making decisions that focus on the client's needs and that engage the client as a participant.

Discussion

Service provision occurs directly with individuals, groups, programs, or organizations. Depending on the setting in which the occupational therapy practitioner works, various terms may be used for individual clients (e.g., patient, consumer, resident, participant, student, teacher, employer, or administrator). Group clients may include families, teams, or others with common needs. Within society today, "family" has a broad definition, as families can be configured by birth, adoption, marriage, or from a feeling of mutual support in relationships (Ray Graham Association for People With Disabilities, 1993). Programs generally fall within some organization, thus occupational therapy services may be directed either at specific programs or at the organization itself. For example, health promotion, work-injury prevention, or accessibility design programs may be developed for industries, business, or local government.

Client-centered service delivery emphasizes the importance of the collaborative process that occurs between the occupational therapy practitioner and the client. Collaboration is a mutual working together to determine the issue(s) of priority, how the issues will be addressed, and how the occupational therapy practitioner will be involved (Letts, Fraser, Finlayson, & Walls, 1993). By negotiating and working together, occupational therapy practitioners and clients can target goals and identify activities that will meet client needs, whether they are individual, programmatic, or organizational. In situations where the client is unable to actively collaborate, the occupational therapy practitioner works with the family, caregivers, or significant others. Thus, the client-centered approach demonstrates respect and value for the client's needs, wants, and priorities.

Service delivery cannot be considered in an isolated fashion because it exists within larger interdependent systems that are dynamic and interactive. For example, an individual who is receiving occupational therapy services is part of a family system and a community system, and may be part of a work, school, and/or reimbursement system. The practitioner needs to acknowledge and appreciate all of the systems that affect the client to make sound decisions about service delivery. While payment systems influence service delivery, it is critical that reimbursement not be the primary force when determining services. Core values and beliefs of the profession provide a strong base for the occupational therapy practitioner in determining services (AOTA, 1993a). Practitioners must diligently adhere to ethical principles to ensure that only appropriate and needed services are provided (AOTA, 1994a).

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Temporal, environmental, and cultural contexts are considered by the occupational therapy practitioner in service delivery (AOTA, 1994c). Temporal contexts that impact performance include age, developmental stage or phase of maturation, place in life cycle or phases, and disability status. Environmental contexts that impact performance include physical and social influences such as geographic location, transportation, and living situation. Cultural contexts to be considered include customs, beliefs, activity patterns, behavior standards, and societal expectations. Political, educational, employment, and economic aspects are also included in cultural contexts (AOTA, 1994c).

Occupational therapy practitioner roles vary in scope in order to meet the needs of various clients. The *Occupational Therapy Roles* document (AOTA, 1993b) identifies 12 roles commonly assumed by OTRs and COTAs, ranging from practitioner to entrepreneur. Roles are not exclusive, because jobs performed by practitioners may include aspects of more than one role. For example, the practitioner provides services to patients, clients, families, and systems; the administrator provides services to personnel and the organization; and the educator provides services to students, consumers, or peers.

Occupational therapy practitioners rely on their core values and code of ethics in making service delivery decisions, while abiding by federal, state, and local regulations. For example, employers' policies and approaches to service delivery may vary. From an organizational standpoint, the occupational therapy practitioner is expected to carry out specific tasks and roles on behalf of the employer. Employers may use reimbursement or productivity, rather than the client's needs, wants, and priorities, as their guides to service delivery. The occupational therapy practitioner must weigh system demands, client needs, and professional values and ethics to make difficult decisions relative to service delivery.

Conclusion

This paper asserts that the client is the central point from which intervention decisions are made and emphasizes the interactive working relationship between the occupational therapy practitioner and the client. Roles within the profession are recognized as expanding and being increasingly interdependent. Service delivery decisions rely on careful assessment of the system, model, and context within which the client exists. Thus, the client-centered approach to service delivery is responsive to the ongoing changes in society and in the profession of occupational therapy.

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Appendix C (continued)

APPENDIX

Background

In 1991, the Representative Assembly (RA) charged the Intercommission Council (ICC) to establish a task force to study "The Use of Personnel Other Than OTRs and COTAs to Provide Occupational Therapy Services." The ICC charged the Commission on Practice (COP) to appoint a task force to investigate this issue and generate a report to be presented to the RA at the 1993 meeting. The task force report included a number of recommendations that were adopted, and as a result, a new task force was convened. One of the charges from the RA was to develop a statement defining service provision to be congruent with the *Standards of Practice for Occupational Therapy* (AOTA, 1994).

The first task force found that the term *service provision* was not adequately defined. Although some state regulatory laws address the issue of the use of aides to provide occupational therapy services, there was no clear indication of what constituted occupational therapy service. In reviewing Association documents, it was also apparent that a definition of service provision did not exist. We were able to find some reference to service provision in the *Guidelines for Occupational Therapy Services in School Systems* (AOTA, 1989). In this document, service provision was described as including three types: direct, monitoring, and consultation (Dunn, 1991; Gilfoyle & Hays, 1980). Thus, the task force was charged to develop this document which puts forth the concepts of service delivery.

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